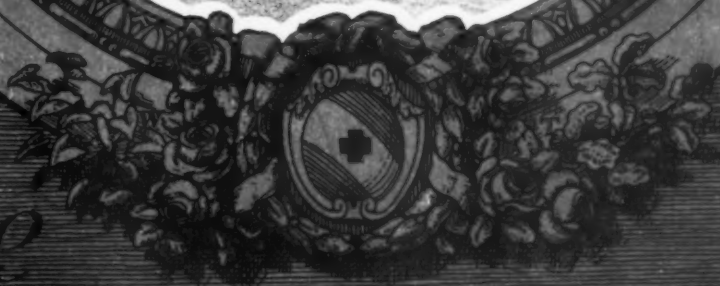
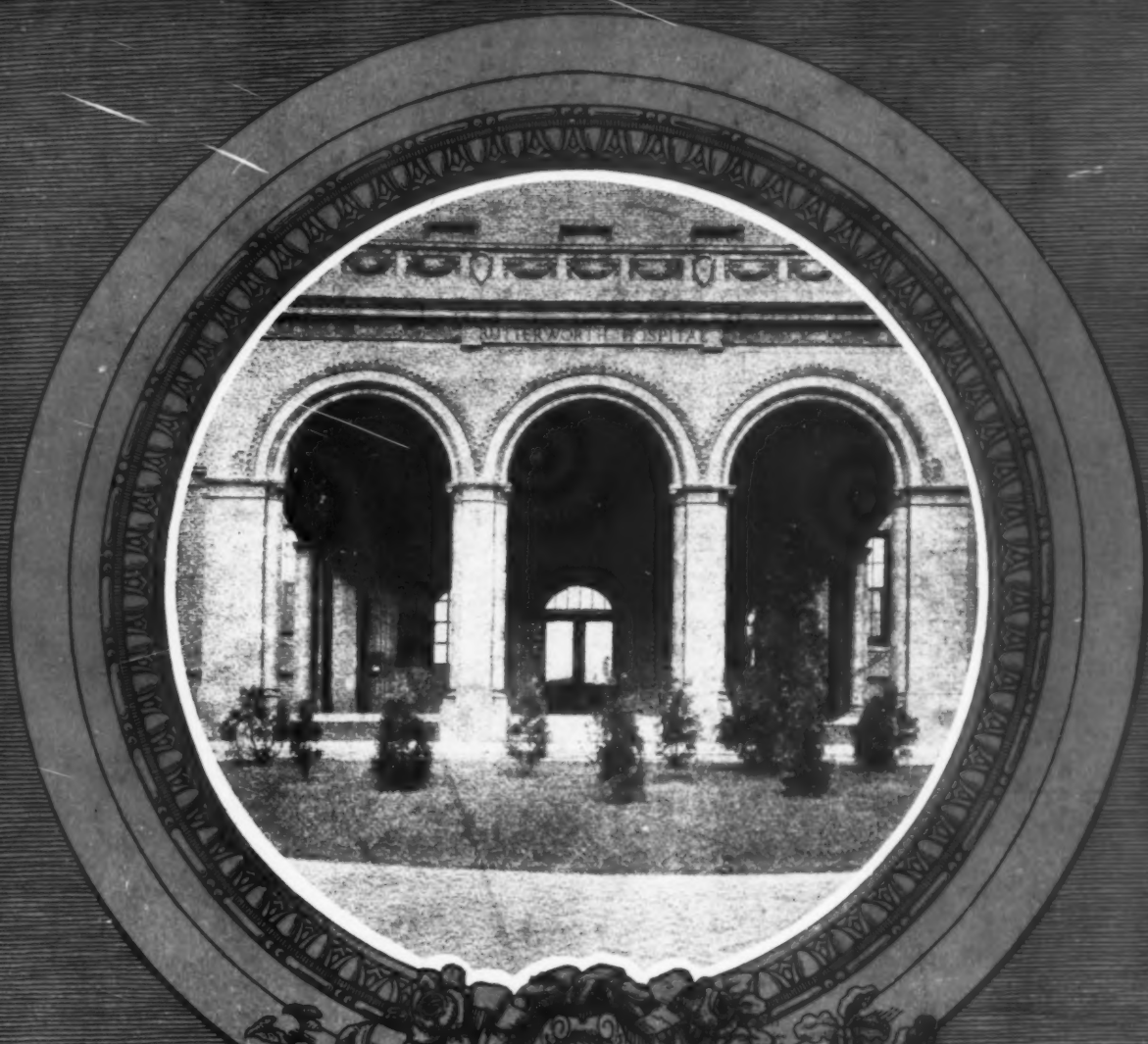


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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXVIII

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ALAMEDA COUNTY HOSPITAL PLAN IN ACTION

WITH the establishment of the Alameda County Institutions Commission in July, 1917, was launched a community experiment of unusual significance, which was to unite the various institutions for the care of the indigent sick throughout the county and bring together for cooperative effort the welfare agencies as well.

Alameda County, California, comprises some 172 square miles of territory, with a population of nearly half a million. The western portion lies along the shores of San Francisco Bay. Here on the lowlands and rising foothills are situated the larger cities of the county: Berkeley, with a population of 80,000; Oakland, with a population of 300,000; Alameda, with 34,000 citizens, and the smaller communities of Piedmont, Albany and Emeryville. The population of these districts is distinctly urban, the cities combining residential sections and business and industrial centers. From the Bay, Alameda County stretches 38 miles to the east across rolling hills to the Livermore Valley. The eastern end of the county is distinctly rural in character, country homes giving way to truck farms and chicken ranches, and then to fruit ranches, dairy farms and stock ranches as one travels east.

Prior to 1917 conditions existing in Alameda County for the care of the dependent poor in times of sickness were deplorable. The county hospital—the Alameda County Hospital, San Leandro—consisted of a group of dilapidated structures, entirely lacking in facilities for the proper care of the sick and fitted with obsolete equipment. In the center of the group was a corral for cattle and a dairy for milch cows, and within a few hundred feet, on the top of a hill, was a building for the care of acute communicable diseases. The combination of milk, flies and acute

communicable diseases was vicious. The acute and chronic sick, the dependent aged and the unfortunate young were all herded together in this common institution. The standard of professional care was low and it was difficult to hold a desirable staff.

Out of this arrangement grew an impossible situation. The acutely sick persons suffered from neglect, often ultimately becoming chronic cases and permanent county charges. Admissions were inaccurate, often resulting in undeserving people becoming wards of the county, buildings fell into decay and methods failed to keep up with modern knowledge.

Abuses resulting from this inheritance of the past gradually aroused general indignation and derogatory articles appeared in the press. Public opinion demanded that steps be taken to work out some remedy and a group of interested citizens petitioned the county board of supervisors to take action.

What Investigation Revealed

Thereupon the state board of charities was requested to make an investigation and in accordance with the recommendation embodied in their survey an ordinance was adopted, creating a special commission of seven members to whom were delegated the administration and control of the county institutions for the care of the sick.

The members of this commission, each of whom possessed some special knowledge that would be of value to the work, included a business man, an attorney, the chief surgeon of the Emergency Hospital, a university professor, a labor leader and one woman, a college president. The members of this advisory body serve without pay.

Investigation and study revealed that the problems resolved themselves into the following:

First, care of the acute sick, including communicable diseases.

Second, care of the convalescent, and provision for maintenance of the chronic sick, including advanced tuberculosis cases and the indigent aged.

Third, care of curable tuberculous patients.

Fourth, preventive medical care for children.

Each of the foregoing required different standards to obtain the best results at the minimum cost, and after deliberation the solution of the different elements in the problem was worked out somewhat in the following manner:

About 1914 or 1915 a movement had been started for the building of a new county hospital in the city of Oakland and a committee was appointed which went into this matter in a thorough manner from a countywide standpoint, and, over a long period, studied by means of pins in a map the home addresses of patients who went to hospital. In this way it was demonstrated that the ideal location for a large general hospital for the care of acute medical and surgical patients was in East Oakland, near to but not in the midst of the industrial development that was taking place in that neighborhood. Here now stands the recently completed Highland Hospital of Oakland, fulfilling the first requirement of the Institutions Commission's plan.

The site was purchased only after an exhaus-

tive examination of properties in all parts of the city of Oakland. It was chosen owing to its wonderful elevation and its isolation from any probable encroachment of industries or business of any objectionable nature. Against it was its hilly location, and although the purchase price was low, about \$30,000 for nine acres, it was realized that much money would have to be spent in grading this property in order to get a proper building platform. Subsequent to the purchase of this property an additional purchase was made to the extent of a little more than six acres, so that now the county owns, to the street line in all directions, about fifteen acres, which will be sufficient doubtless for all future possible development.

The hospital has been built for future expansion. All the services of whatever nature are fully developed. The number of beds at the present time is about 400, but these can be added to so that the probable future demands of an increasing population in the county can be met for years to come. The average patient remains in Highland Hospital about eight days. As soon as his condition changes from an acute state and becomes sub-acute, convalescent or chronic, he is transferred to what was formerly known as Alameda County Hospital, San Leandro, recently re-christened Fairmont Hospital, another link in the chain of institutions existing for the medical care of Alameda County's sick poor.

In the days when the Institutions Commission started to reorganize the work of rendering medical aid to the poor of the county, the Alameda





Airplane view of Highland Hospital, Oakland, Calif.

County Hospital was, as has been stated, in a run-down condition and unfit in all respects for the rôle it was designed to fill. It was necessary, however, that until the completion of the new, large general hospital for the care of acute cases, the institution at San Leandro should continue to give medical service to these patients.

Immediate reconstruction of the important buildings of the hospital was therefore planned, and a comprehensive scheme of development arrived at. Surveys were made of existing buildings and proposed improvements were studied in their ultimate relationships to the future permanent group of buildings that was to be erected. The standard of equipment, organization and care was raised and a new order of things reigned throughout the institution. In short, the old hospital was gradually metamorphosed into a well ordered institution, and in its reorganized form and under efficient administration was approved by the American College of Surgeons as having met its minimum standards. Farms, gardens, shops and industries were developed, so that the inmates and convalescent patients may, wherever possible, through their labor reduce the cost of maintenance of the whole hospital system.

Up to September, 1926, acute cases continued to be cared for at this institution, but with the opening of the Highland Hospital at that time, all such cases, with the exception of acute tuberculous patients, were transferred to Highland, thus leaving the old county hospital to be carried on entirely for the care of the chronic, the convalescent, the aged, and also the tuberculous patients who are in the advanced stages of the disease. Here, therefore, has now been met the second requirement of the Institution Commission's plan.

In this manner the patient who is acutely ill can be efficiently and effectively treated in a modernly equipped hospital and rapidly restored to society. At Highland Hospital this care costs five dollars a day, but is of short duration. At Fairmont Hospital, on the other hand, \$1.50 is the per diem per capita cost. It is therefore good financing to transfer patients as quickly as possible. Moreover, the patient being sent to the country is removed from the environment of the hospital and sickness, and as he gradually becomes convalescent he is able to be in the fields where he can take exercise, become sunburned, and can later do a certain amount of work, in this way being able to return to the county in some measure the cost of his maintenance and care. A visit to Fairmont and talks with the patients there will convince anyone that these patients are happy—happy to a greater degree than is common in groups of people of a comparable type. This is evidence that the patients' welfare is in no way sacrificed for such economic gain as their labor may produce but rather that the therapeutic value of the work is the first consideration in the minds of those responsible for the operation of Fairmont.

It is never desirable for chronically sick persons to be cared for in the same institution as acutely ill patients. Such a practice, which is of course common in county institutions, too often results in the chronic patient being neglected and in many cases regarded as an encumbrance. The care of the chronic sick calls for especial knowledge of their diseases. Such patients should be in an environment where they can be in the country, can be out of doors and can have as much freedom as possible, which is not practicable in a

modern hospital in a large center. Neither would it be possible under such circumstances to develop the industrial end of the work on a large scale as has been done at Fairmont Hospital, where for the fiscal year 1925-26 the production of wealth from the farm industries alone, including milk,

patients who are likely to get well, those who have been classified as incipient or moderately advanced types of pulmonary tuberculosis, are granted admission to Arroyo. To this fact is due the hopeful and happy atmosphere that pervades the institution. Sound psychology is responsible for



General view of Fairmont Hospital, San Leandro, Calif., showing the farm buildings on the left.

chickens, eggs, vegetables, pork, bacon, and hams, amounted to \$51,980.09, this figure being based upon the market cost of these products and including the charging off of 2 per cent monthly for depreciation, 6 per cent interest on investment and all the other charges that a commercial concern would have to consider in order to create a paying investment.

In the laundry at Fairmont Hospital the entire laundry work for Highland Hospital, Arroyo Sanatorium and Del Valle Farm, as well as for Fairmont, is done, and done almost entirely by inmate labor, the only hired help being a washer and two finishers. These patients are able to work, but because of their various ailments and infirmities they work slowly and spasmodically, and it may take perhaps four of them to do the work that two able-bodied persons could accomplish. For this reason they could never hold a job in any commercial concern. Yet such labor as they are capable of is here salvaged and produces wealth, while the individuals themselves are happier for two reasons—because they are occupied instead of idle and because they are enabled to contribute toward their maintenance. Surely this is, indeed, real political economy.

It has been shown how the acutely sick, the convalescent, the chronic and the aged are provided for under this Alameda County hospital plan. Let us see what has been planned for the curable tuberculous patients. For them there exists Arroyo Sanatorium, a group of buildings lying in the foothills overlooking the Livermore Valley, five miles south of the town of Livermore. As has been stated, cases of advanced tuberculosis are cared for at Fairmont Hospital and only those

the arrangement that instills in the minds of Arroyo's patients the happy thought that everyone gets well at Arroyo and that therefore they, too, will recover. The physician could have no more valuable aid in his treatment than such an attitude of mind.

Arroyo Sanatorium was partially built by the Alameda County Board of Supervisors before the creation of the Institutions Commission, and commenced operation in December, 1917. Under the direction of the commission, however, the buildings were enlarged, the work developed and the institution dedicated to the care of curable cases only, instead of, as formerly, to the care of both early and advanced cases.

About a quarter of a mile from Arroyo Sanatorium, further down the hillside, lies Del Valle Farm, another agency in the hospital system of Alameda County. This is a preventorium for the care of children who are predisposed to tuberculosis. It was built by the Alameda County Tuberculosis Association, is financed by community chest funds and is administered by the County Board of Supervisors. It is under the direct medical supervision of the staff of Arroyo Sanatorium.

These, then, are the institutions that exist in Alameda County for the care of the sick.

It is necessary, however, to consider the problem of caring for the health of the people from another viewpoint—that of preventive medicine. Something has to be done to prevent people from getting sick and to teach them the fundamental laws of health. Some organized institution should be placed between the people and the institutions for the sick. The answer to this is the modern

health center. Here is another essentially important link which completes the chain of service that is helping to solve the greatest community problem.

Coincident with the work of the Institutions Commission has been developing the work of another related activity—the Public Health Center of Alameda County, having its headquarters in the Ethel Moore Memorial Building, Oakland, and with a branch treatment center in Oakland and eleven consultation centers.

The Alameda County Public Health Center was organized in the latter portion of 1919. Its purpose is to increase the efficiency of public health, relief and welfare work in the community by:

1. The consolidation, maintenance and improvement of clinics of all kinds.
2. The installation for their use of complete scientific laboratories and a well organized pharmacy.
3. The direction of popular education in hygiene and sanitation.
4. The elimination of duplication and overlapping in the field of community service by coordinating health, relief and welfare agencies through the maintenance of a County Agencies

a member of the governing boards of the branch centers and is also an officer in several of the chief public and private cooperative organizations.

The Ethel Moore Memorial Building is the diagnostic center for the Public Health Center and as such houses a clinical laboratory and an x-ray department to which patients from treatment centers are sent for special tests and x-ray photographs. Electrocardiographs and metabolic rate tests are also made. In addition to these diagnostic helps, the building is equipped with special examining rooms. It has been found that of the patients attending the various treatment centers, about 5 per cent need intensive diagnostic study and for these patients this special diagnostic equipment is made available and certain diagnosticians give their services in special clinics. The findings in all of the diagnostic work are sent to the physicians and health centers from which the patients come, and the patient is referred back to his treatment center.

In addition to the diagnostic clinics several special clinics are held in the Ethel Moore Memorial Building to which patients are referred from the treatment centers or other places. Examples are the asthma, diabetic, and cardiac clinics, and here



View showing Del Valle Farm in the foreground, with Arroyo Sanatorium farther up the hillside.

Clearing House and a Social Service Exchange.

The governing body of the health center is an executive committee composed of eight members, chosen annually by representatives of various organizations, public and private. The director, appointed by the executive committee, is ex-officio

intensive diagnostic, treatment and educational work is carried on. Another special clinic is the child guidance clinic whose staff comprises a psychiatrist, a psychologist, a nurse and a social worker. Problem children are referred to this clinic from the schools, the juvenile court and

other agencies, for special study and assistance.

The dental clinic is also located in this building and patients are referred here for all necessary dental work.

The Ethel Moore Memorial Building also houses three coordinated agencies—the Health Development Department of the Oakland Public Schools, the Alameda County Tuberculosis Association and the Oakland Visiting Nurse Association, organized in 1923.

Affiliated health centers are established at strategic points in the county where need for them has been evidenced. The out-patient care of Alameda County's ambulatory patients is carried on by three separate groups of health centers, each of which serves its own district. These groups are:

Alameda City Health Center, serving the city of Alameda, established in 1921.

Berkeley Health Center, serving the cities of

stitutions for the care of the sick, which have been discussed above. The health centers act, in fact, as the out-patient departments for the institutions, none of which maintains any such department. Here the ambulatory indigent sick person makes his first contact with medical aid. Here he is examined, his case diagnosed and treatment prescribed, and from here he is transferred, if hospitalization becomes necessary, to one of the four institutions operating under the Alameda County hospital plan, the entrance medium being the social service department of Highland Hospital which serves as the admitting department for all these institutions. The health center is not only the original point of contact, it is also the terminal point of contact in the Alameda County health system, since it is through this agency that the follow-up work is carried on with the patient after he is discharged from the hospital and has returned to his home and his work.

The Ethel Moore Memorial Building, Oakland, Calif., headquarters of the Public Health Center of Alameda County.



Berkeley and Albany. This was established in 1908.

The Public Health Center of Alameda County, and health centers of the rural communities in the eastern part of the county. This group of affiliated centers serves the balance of the county not covered by Alameda City and Berkeley.

While operated as separate and independent organizations and occupying natural geographical districts, these agencies are closely united through a conscious desire for cooperation, and through participation in the County Agencies Clearing House, an unofficial association of all agencies receiving county support. Through this relationship uniform policies and standards have been developed and maintained in the out-patient work of the entire county.

Although the various health centers function primarily as agencies of preventive medicine their work is linked up in a vital manner with the in-

Such, then, have been the origin, organization and purpose of what has come to be known as the Alameda County hospital plan, which has been evolved and developed over a period of approximately nine years. It has abundantly and conclusively proved its essential value to the community and should place the county in the first rank in the country in regard to the provision made for the care of its dependent poor in time of sickness.

The work has reached no conclusion but on the contrary will undoubtedly develop and broaden its scope, thus becoming increasingly valuable to the community. However, with the completion and going into operation of Highland Hospital, the original plans of the Institutions Committee have come to splendid fruition, and it seems now a fitting time to pause and review past accomplishments.

The outstanding feature of this whole plan, the feature that differentiates it from most other systems of caring for the sick poor, is the fact that here is found one vast organization, whose component parts are the hospitals and health centers scattered throughout the county. These different elements are all working in unity toward a common end—the prevention of sickness and the restoration of health where sickness occurs. Their services are interwoven; they are playing into each other's hands; they are doing the finest kind of team work. The men who direct the different units cooperate with each other eagerly in every possible way, each feeling that his institution does not exist as a complete and independent whole but rather as a vitally important part of an infinitely greater whole.

The Commission has been singularly fortunate in the man it appointed in the early days of the work to become its director of hospitals—Dr. R. G. Brodrick. Dr. Brodrick was at that time director of the San Francisco City and County Hospital which was planned and built under his direction. He was asked to take one year's leave of absence and come in consultation with the

Commission. At the end of that time he was asked to remain on a five-year contract, at the expiration of which a similar contract was drawn up. Dr. Brodrick had the ability to envisage the whole interlocking scheme of health and hospital service: he has had the forcefulness to surmount difficulties and the singleness of purpose that ensures the best results. He is the key to the success of the situation as it exists today. No individual institution could in any way approximate the type of service that Alameda County renders in all of its phases to its indigent sick, and no group of institutions could be successfully operated were they not guided by a man whose philosophy was all-encompassing and sound.

In the following pages detailed descriptions are given of the different units that go to make up Alameda County's health and hospital service, with the exception of Highland Hospital, which was fully discussed in a comprehensive article in the March issue of *THE MODERN HOSPITAL*. From among the various health centers Berkeley Health Center has been selected for description here, the work carried on there being more or less typical of that done in the other units.

HOW BERKELEY HEALTH CENTER FUNCTIONS

By Marguerite L. Spiers, Director of Social Service, Berkeley Health Center,
Berkeley, Calif.

THE Berkeley Health Center, Berkeley, Calif., typifies in its development the evolution of public health.

In 1908 the organization was first incorporated as the Berkeley Clinic for treatment of the sick poor, an outgrowth of a small settlement in West Berkeley. Later the name was changed to the Berkeley Dispensary, and in 1915 the plant was enlarged from a small rented home to a building erected and owned by the dispensary. With this growth, increased clinic facilities were made possible and treatment services were extended to a larger number of individuals. Still the work of the agency was confined chiefly to treatment of the sick poor—a selected group of the community's population in need of free medical aid.

Gradually a group of preventive services was added. But during this period the dispensary was reaching a limited group.

Stimulated by the growth of the health center movement, there arose the desire to make available health education and preventive services to the entire population of the community, and developments were made along this line.

When a clinic or dispensary arrives at this stage in its development it is no longer a clinic, or group

of clinics, but has become a health center, serving potentially 100 per cent of the population, instead of confining its services to a small portion of the community.

This transition occurred at the Berkeley Dispensary slowly and naturally, as an outgrowth of the demands of the community. When finally the name was changed from Berkeley Dispensary to Berkeley Health Center, the transition period had already passed and the community had come to use the agency as a health center and to support it as such.

Undoubtedly this gradual growth and demonstration of the need and results of the work before support was asked for new activities, has been the cause of the excellent backing that this agency has received from the entire community.

In the accompanying table the present health center functions are listed according to that portion of the community which they serve—the entire population or the sick poor.

The health center as a private corporation is deputized to act as official health agency for the community in rendering the services listed in chart No. 1.

Its funds are derived from the County of



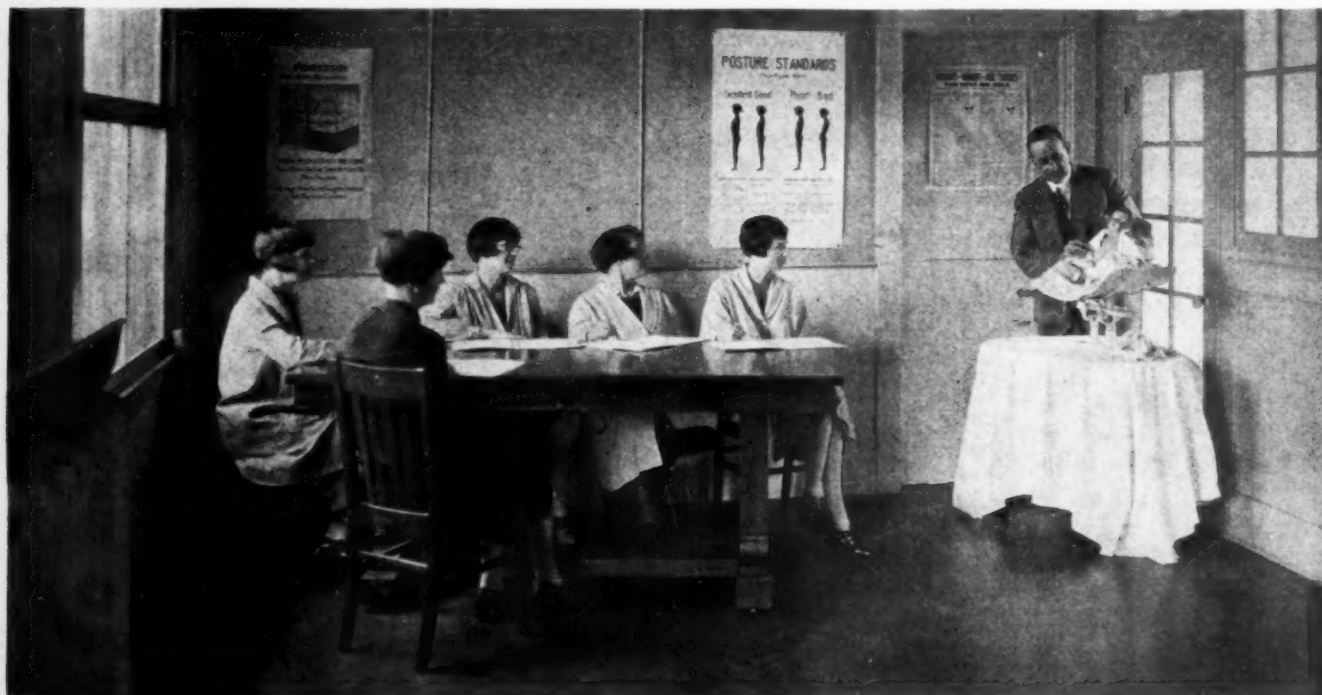
The health center nurse is also school nurse

Alameda, City of Berkeley, Berkeley Community Chest and private contributions for building or other special purposes.

It thus becomes the official agency for county and city medical relief in Berkeley, as well as headquarters for much of the preventive work of the city health department and schools.

This close relationship to health department and

board of education is brought about in the following way: The health officer of Berkeley is also medical director of the Berkeley Health Center, as well as director of health education in the public schools. Likewise, all health department nurses hold two other appointments. They are school nurses and field nurses for the health center. The health department, public schools and health cen-



Training of students is an important part of the health center work

ter each pays a portion of the salaries of the health officer and the public health nurses.

In this way there is centralization of health work in the city, resulting in efficiency of operation, economy and prevention of duplication.

Thus, the health center is a private corporation, the chief executive of which is the official representative of the city in all health matters. Under this medical director are three departments of equal rank, and the medical and dental staffs.

The work of these departments is as follows:

Department of Field Nursing: The district plan is followed in the public health nursing work of Berkeley. The city is divided into eight districts with a public health nurse supervisor in each. These nurses are responsible for carrying out the following functions in their own districts: Pre-

fields covered in this way are such as tuberculosis and child hygiene.

Students enrolled in the public health nursing course of the University of California receive their field training in this nursing service, under the direction of the supervising nurses and a field instructor from the university.

Department of Institutional Service: The public health nurse spends her entire time in the field. Within the health center building is another department of nurses and other workers who carry on the services necessary in the conducting of clinics, maintenance of building and supplies, bookkeeping and budget administration. The personnel, as shown in the organization chart, covers the functions usually covered by such workers in any medical agency. However the institutional



Berkeley Health Center, Berkeley, Calif.

natal advice; postpartum care; child welfare; school nursing; discovering cases needing the services of a social worker; communicable disease control; tuberculosis nursing; follow-up and home care of any type of illness; foster homes investigation (of homes not investigated by the child placing agency); bedside nursing; health education; metropolitan nursing; field training of university students in public health nursing.

Patients to whom the above services are given may be clinic cases or patients of private physicians. When able to do so, they are asked to pay a small fee for nursing care.

Through this plan one nurse fulfills in her activities the functions that would be carried out by several under a specialized nursing plan.

In order that each nurse may keep an active interest and perfect her technique in certain special types of work, an advisory system is maintained. Each adviser is a specialist in his or her own field and is responsible for keeping that type of work up to as high a standard as possible. The

service nurses do only clinic nursing and do not go into the field.

Department of Social Service: Through the health center social service department comes the contact between the organization and all outside individuals and agencies. It is a liaison department, a case work agency within the health center, and through it the health center is linked to the county institutions.

The plan of centralization is carried out here just as in the office of the medical director and the department of field nursing. The superintendent of social service holds three other positions: Advisor in tuberculosis for the city health department, lecturer in tuberculosis for the California Tuberculosis Association and lecturer in medical social service in the department of economics of the University of California. This plan coordinates the social work of the health center with other departments of city and county health work.

As in the department of field nursing, the function of training students becomes an important one

here, and through this teaching in both departments the health center is brought close to the university, and has become a training center in practice work for university students in public health nursing and medical social service. The medical social service group do their practice work under the supervision of the health center social workers.

The health center social work is conducted under a generalized plan, comparable to that of public health nursing. The public health nurse is potentially in contact with 100 per cent of the homes in her district, while the medical social worker carries a much smaller case load. There-

need of material relief); follow-up; health education in connection with clinics; training of students; services in clinics; services to physicians, as follows: procuring of information concerning social background of their patients; seeing that recommendations of physicians are carried out; making clear to patient or family the medical diagnosis and insuring their cooperation; securing a complete medical history of each new patient and searching for other medical needs than the one for which aid was asked.

In addition to these social case workers, whose duties are performed both in the field and in the

Functions of Berkeley Health Center

Preventive

Services to well people, regardless of financial status.
Child guidance.
Child welfare, including arrangements for private preventorium or summer camp care.
Sunshine school.
Eight neighborhood child welfare conferences, scattered throughout the city.
Nutrition clinic.
Consultation and advice in any treatment clinic.
General information regarding public health and social welfare.
Health education.
Health examination.
Immunology.
Medical-social case work and follow-up.
Neuro-psychiatric service for adults.
Prenatal conference.
Public health nursing.
Tuberculosis work, including supervision, advice, and arranging private sanatorium care.

Curative

Dispensary services to sick people who are unable to pay for private medical care.
Cardiac.
Dental.
Dermatology.
Endocrinology.
Ear, nose and throat. Eye.
Gastro-enterology.
Gynecology.
Hospitalization—arranging admission to county institutions and free service of other hospitals.
Medicine.
Obstetrics, including prenatal care, confinement in homes and postpartum care.
Orthopedics.
Physiotherapy.
Pediatrics.
Tuberculosis—diagnostic and after care.
Urology.
Venereal—included in dermatology and gynecology.
All services offered to well people are also offered to this group.

fore, the nursing districts are approximately half the size of those of the social workers.

Here, again, the advisory plan is followed, with an adviser in eligibility standards, case work technique, tuberculosis, mental hygiene and juvenile court procedure.

Each social case worker is responsible for carrying out the following functions in her own district, both for health center and county institutions: Eligibility determination; social diagnosis; social case work, when family is not being carried by another case work agency (about 60 per cent of all health center families requiring case work are not known to other agencies, and are not in

health center, the social service department maintains a staff of indoor workers who are responsible for all first contacts with social service, for being hostess to patients, maintaining a general information service, operating the follow-up system, caring for all slight service cases and conducting the bureau of volunteer workers.

The foregoing is descriptive of the general plan and organization of Berkeley Health Center. A complete cross section of its work is not possible in the space allotted. However, its connection with county institutions may be briefly outlined.

Through its out-patient services the health center endeavors to prevent need of hospitalization,

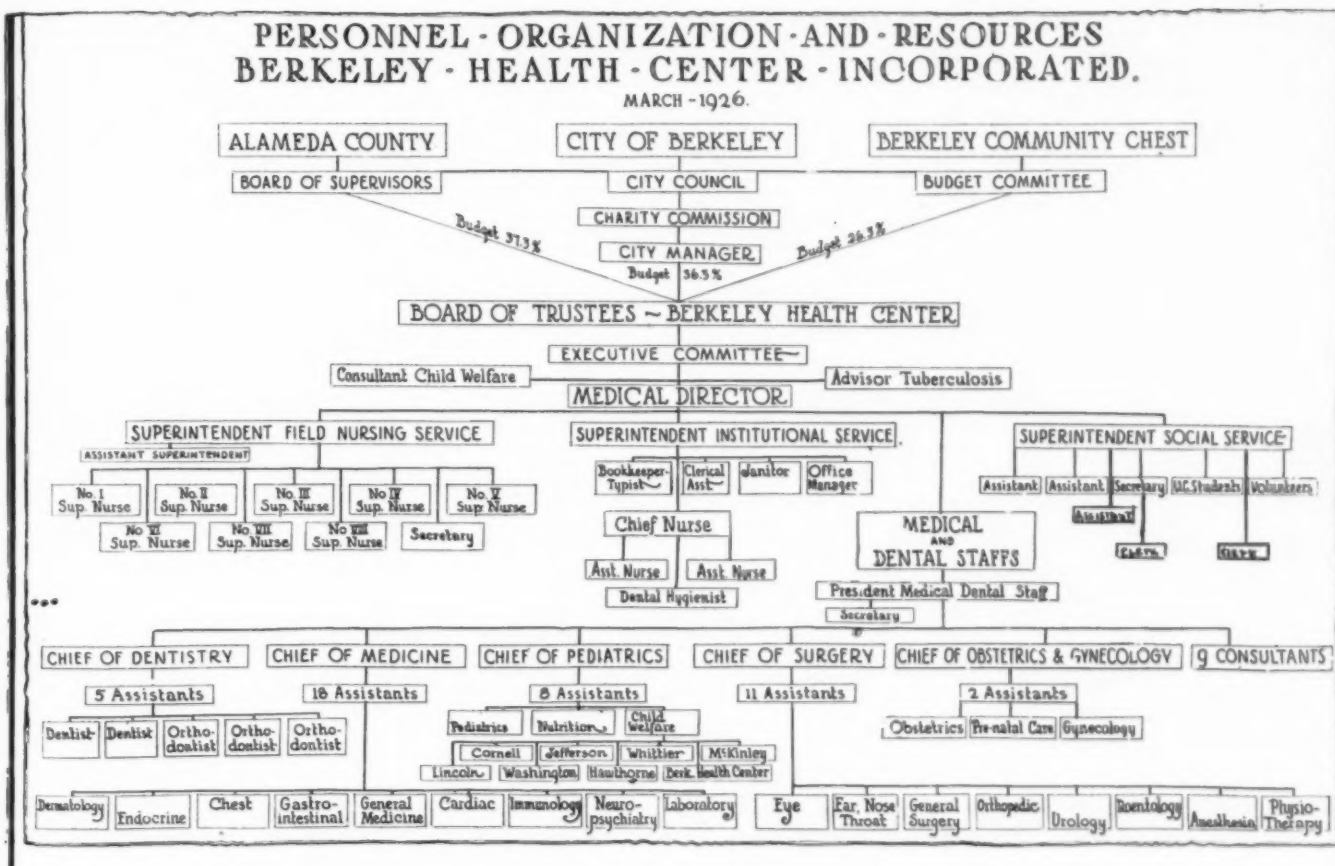


Chart No. 1.

and when this can be done the saving of county funds in treatment cost alone justifies the effort and expenditure for preventive work. (See chart No. 2.)

When hospitalization becomes necessary, maxi-

mum efficiency in treatment of the case can be obtained only when continuity of out-patient and hospital care is available. This continuity has been made possible in the Alameda County health plan through a health center and hospital follow-

CLINICS	ALL SERVICES				INST. SERVICE		SOCIAL SERVICE		FIELD SERVICE	
	No. of Patients	Cost per Patient	Number Contacts	Cost per Contact	Number Contacts	Cost per Contact	Number Contacts	Cost per Contact	Number Contacts	Cost per Contact
All Clinics	4,725	\$ 9.03	40,011	\$ 1.07	16,770	\$1.91	2,049	\$.42	2,750	\$.66
Dental	711	17.53	6,685	1.86	3,361	2.96	3,213	.76	111	.66
Dermatology	165	4.63	806	.95	383	1.59	395	.34	28	.66
Gynecology	146	9.03	1,424	.93	533	2.23	794	.08	97	.66
Immunology	357	4.78	1,346	1.28	1,237	.98	1,332	.36	14	.66
Medicine (Adult)	676	5.72	4,516	.86	2,143	1.13	1,971	.60	402	.66
Neuro-Psychia. (Child)	73	11.62	473	1.79	136	3.11	299	1.34	38	.66
Neuro-Psychia.	127	16.05	1,333	1.53	333	3.03	933	1.06	67	.66
Obstetrics	59	47.62	1,184	2.37	341	6.72	504	.58	339	.66
Ophthalmology	286	5.15	1,541	.95	725	1.56	771	3.93	45	.66
Orthopedics	243	10.40	3,892	.66	1,743	1.30	2,028	1.50	121	.66
Oto-rhino-laryngology	500	3.81	2,559	.75	1,097	1.16	1,191	.38	271	.66
Pediatrics (Incl. Nut. & Child Wel.)	738	3.90	5,600	.52	1,949	1.53	3,119	1.26	532	.66
Surgery	352	11.25	2,286	1.74	1,261	2.72	936	.45	89	.66
Tuberculosis (Incl. Arroyo & Del Valle)	203	11.19	3,031	.80	708	1.87	1,871	.45	452	.66
Urology and Venereal	89	18.23	2,035	.79	820	1.69	1,134	.16	81	.66

Berkeley Health Center unit costs for 1924.



Patients discharged from Arroyo Sanatorium, Livermore, Calif., are kept under medical supervision at the Berkeley Health Center.

up system. Through this plan, every patient is followed up until his case is terminated. If he goes to a county institution, he must go through the health center, and he remains an open case in the files of that agency. The health center social worker automatically keeps in touch with him through the hospital period, and is ready to arrange out-patient treatment for him immediately

after he has been discharged from the hospital.

This worker determines whether the patient's home is such as to permit convalescence there, thus reducing the hospital cost per patient, when possible, and increasing turnover.

This is as true of tuberculosis patients in Arroyo Sanatorium as of cases in the acute wards of Highland Hospital. The worker who sends a pa-

COMPARATIVE COST OF TREATING ONE PATIENT



Chart No. 2.

tient to Arroyo does as intensive social case work for the patient and his family during the sanatorium period as she does before admission and after discharge. The patient is visited regularly and a plan for his future has been well worked out before he returns home. After his return, he is observed regularly by the medical director of Arroyo, who holds a sanatorium after-care clinic at the health center.

The machinery for this continuity of health center supervision and responsibility has been

easily worked out through close cooperation between health center and hospital executives, and through the County Agencies Clearing House.

We have covered here the out-patient work of one of Alameda County's health centers. It is a small, informal organization, closely connected with the training of workers, and vitally interested in the conducting of research. Although the official health agency of the city of Berkeley it is also an integral part of Alameda County's health plan.

WHAT FAIRMONT HOSPITAL IS DOING FOR THE CHRONIC AND THE CONVALESCENT

By A. C. Jensen, Superintendent, Fairmont Hospital
San Leandro, Calif.

FAIRMONT Hospital is located on the Foothill Boulevard about three miles east of San Leandro and about ten miles from the center of Oakland, Calif.

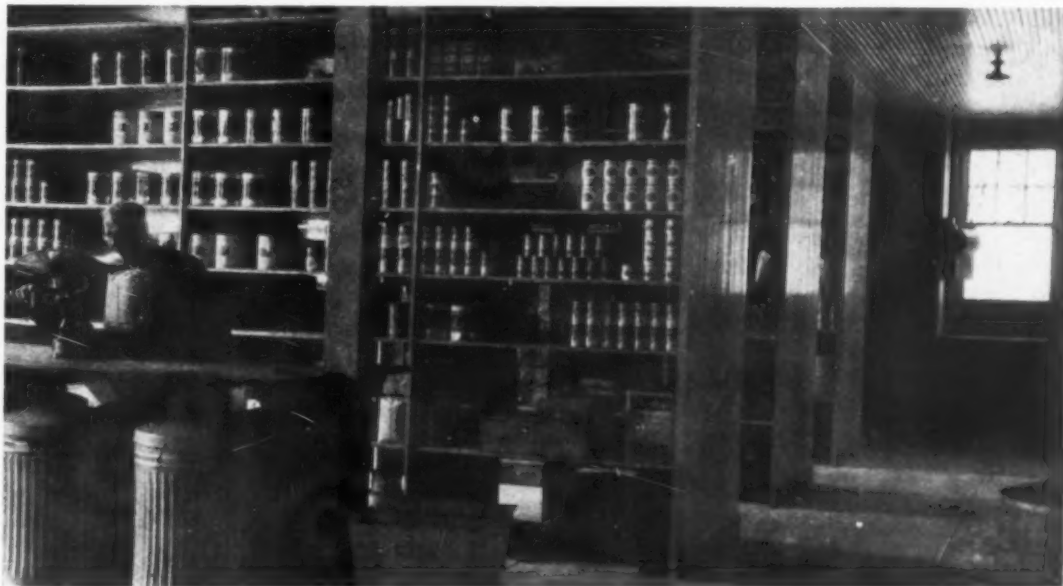
When the present plan of administration and organization was initiated, there were about one hundred and twenty buildings, most of them little better than shacks. The majority of these buildings were built without plans; no record had been kept of location of sewer, water and steam pipes; roads and grounds were undeveloped. All buildings were unsanitary, and equipment was obsolete. There was no proper provision for storage of supplies and equipment, these being scattered about the grounds and in various storerooms, a condition that resulted in constant loss of material.

Although favored with a beautiful location in

the foothills overlooking San Francisco Bay and facing on the Foothill Boulevard, no effort had been made to beautify the grounds by the planting of trees, shrubs or flowers, and the institution was commonly referred to as an "eye sore."

When reorganization of Alameda County's hospital service was planned, it was decided to begin immediate reconstruction of as many of the important buildings in the old hospital as possible. A comprehensive plan was developed which established main axes, roads and sidewalks. Surveys were made of existing buildings, and proposed improvements studied in relation to the future permanent grouping.

The main hospital building was remodeled and furnished with modern hospital equipment, and the professional care of patients raised to the standard required by the American College of



*Storeroom in
old cow barn
at Fairmont
Hospital.*



Brush making at the Community Shoppe

Surgeons and the American Medical Association. The wards for tuberculous patients were removed to a better location and remodeled, and the standard of equipment, organization and care therein raised to meet the requirements of the tuberculosis bureau of the state board of health, with the result that the hospital was granted the state subsidy of three dollars per week for each tuberculous patient. The isolation hospital was rebuilt and equipped to meet the standard of a modern hospital for the treatment of communicable diseases.

Wards were built and equipped for the proper care of chronic patients, and the buildings for the housing of ambulatory inmates were remodeled and put in sanitary condition.

A new service building was erected, providing adequate kitchen and bakery for the entire institution, and dining rooms for the staff, employees and inmates. An employees' home was provided, an adequate power plant and laundry built, and old buildings remodeled.

A dairy, situated on an adjoining piece of property, was purchased. The poultry plant and other farm activities were removed from the immediate vicinity of the hospital to this location; and the old dairy barn, which was a well constructed building, was converted into a central storehouse, with all supplies assembled under the control of a storekeeper.

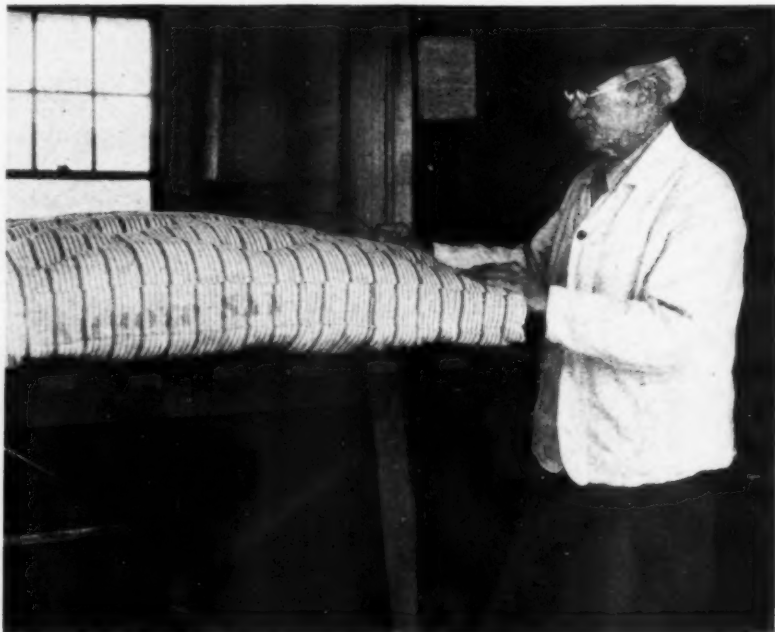
New cast-iron water mains, new

sewers and steam lines were installed; concrete roads and sidewalks laid; and most of the scattered buildings connected by covered pergola walks. The extensive grounds of the institution were developed, and the place changed by trees, shrubs and flowers, from an unattractive to a pleasant, cheerful place.

As Highland Hospital was being built on a yearly appropriation requiring several years to complete, it was necessary to develop a medical organization at Fairmont that would not only meet present needs, but would develop into a nucleus for Highland. A visiting staff of forty representative medical men was secured, the members being appointed by the Institutions Commission upon recommendation of the chiefs of staff and approval of the director of hospitals. A resident medical staff—composed of

a resident physician with twelve interns from Class A colleges, pathologist, competent laboratory, and x-ray technicians, druggist and statistician—was developed. The nurses' training school of low educational standards and with only five or six students, gradually became a first-class school of fifty pupils. This organization was transferred to Highland Hospital when it was opened in September, 1926.

Every effort has been made to coordinate the activities of the two hospitals, avoiding duplication of service wherever possible. For instance, all laboratory work, except simple routine blood counts and urinalysis, is being done at Highland; while Fairmont, with its large laundry and bak-



Making mattresses for Arroyo Sanatorium

ery, its group of completely equipped shops, and supply of cheap labor available among the inmates, is in a position to perform this kind of work for both Highland Hospital and Arroyo Sanatorium.

The present organization of Fairmont Hospital is shown by the accompanying diagram. The Board of Supervisors is the legally responsible body elected by the people, the Institutions Commission is appointed by the Board of Supervisors, and the director of hospitals is appointed by the Board of Supervisors upon recommendation of the Institutions Commission. The superintendent is appointed upon the recommendation of the director of hospitals, the department heads are appointed upon the recommendation of the superintendent, and all employees are appointed upon the recommendation of the several department heads who are held responsible for the work in their departments.

The population of Fairmont is 750 patients and inmates. There are 170 employees.

The problem of Fairmont Hospital has two definite divisions: that of hospital care for the chronic and convalescent sick, and that of "home care" for the aged and infirm.

The medical care is given by the visiting staff of Highland and Fairmont Hospitals and a resident staff of one chief, assisted by one dental and five medical interns. Every effort is being made to keep the standard of medical service on a par



Basket makers at the Community Shoppe

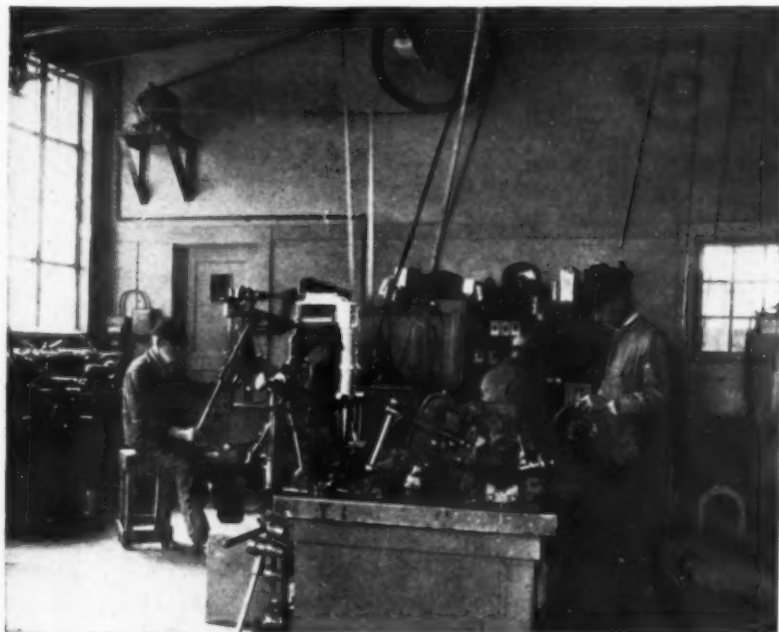
with that of Highland Hospital, as patients are continually being transferred from one institution to another as their condition indicates. All hospital wards are supervised by graduate nurses, assisted by ward maids, many of whom have had some nursing training, and orderlies. As only chronic and convalescent patients are cared for, it is possible to keep the cost per patient below one dollar and a half per day and still give good service.

Patients treated in Highland Hospital who cannot be cared for in their own homes during the period of convalescence, are transferred to Fairmont, where their recovery is hastened by their being among other convalescing patients who are recovering and gradually being discharged from the hospital.

Another important service, that of occupational therapy through employment, is given these patients, when prescribed by the physician in charge.

After an applicant for admission to Fairmont Hospital has been given a permit for admission by the social agent, he presents this at the infirmary. He is then received by one of the doctors, placed in the hospital if he needs this care, and, if not, assigned to a ward in the home. Here he is received by the steward or his assistant, and assigned his quarters, and advised regarding meal hours and institutional routine.

The steward interviews each inmate at the time of admission, noting on the employment card the inmate's name, age, former occupation, and such in-



Machine shops are operated by inmates

On the right and at the bottom of the page are shown two pictures of the same spot, before and after reorganization.



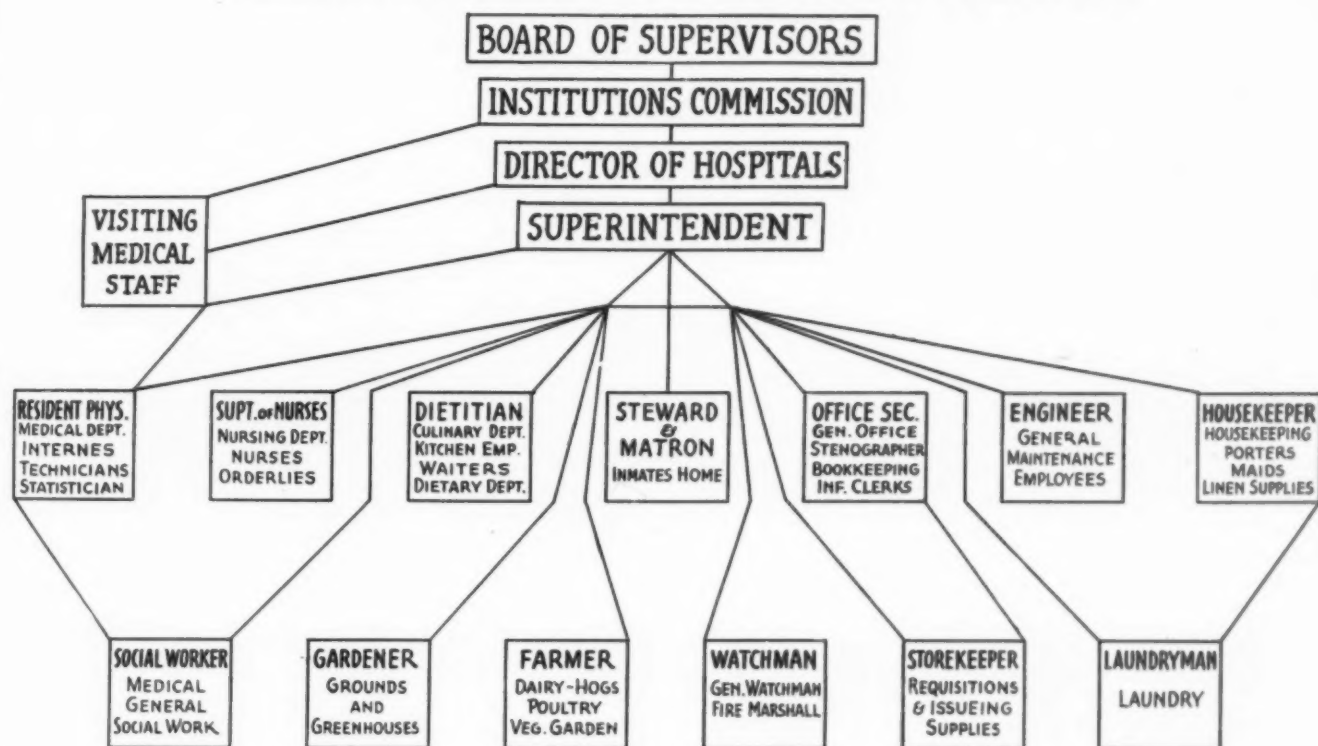
In the center are shown the greenhouses at Fairmont Hospital.

formation as may be of interest in fitting him into the life of the institution. He is instructed to report the following morning for a physical examination by the resident physician. The steward is present at this examination. He confers with the doctor about what the patient is able to do and then assigns him to work if he is able, taking into consideration his former occupation, personal preference, physical and mental handicaps. Often an inmate is temporarily disabled, and he is then put on a pending list and given treatment until such time as he is able to

do so. The following case, one of many, will serve to illustrate this point:

For three years an inmate, seventy-nine years of age at admission, a painter by trade, who was unable to secure employment because of his advanced age and physical condition, was employed in our paint shop. He was a good mechanic, honest and industrious, and did good work in re-finishing furniture and hospital equipment and painting fences. He was advanced until he received \$15 a month, in addition to his maintenance. He more than earned this up to ten days

PLAN OF ORGANIZATION OF FAIRMONT HOSPITAL



be employed. If the doctor finds that he is unable to be employed, he so states on his card. No inmate is employed without the doctor's recommendation. It is frequently necessary to make several transfers before the inmate is finally placed where he can do the best work and be the happiest. This record is kept on an employment card.

No Man Should Be Pauperized

The purpose of this employment is twofold. In the first place, every inmate needs employment to give him an interest in life, and can be happy only when this is supplied. In the second place, no man should be pauperized by being cared for by public or private charities, if he is able to earn his own living either in whole or in part. Many inmates are able to do this under institutional conditions, who would not otherwise be able to

of the time he died. When taken ill with pneumonia he was given the best of care. After his death, the Painters' Union, of which he was a member, conducted his funeral. This man by being enabled to do the work he was able to do and which could only be done under institutional conditions, became an economic asset instead of a liability.

Inmates who do harder work or fill more responsible positions eat in a separate dining room, and are given more meat and desserts, than those who are not employed. In addition to this, those whose work justifies it are paid small sums ranging from \$2.50 to \$10, and, in a few cases, \$15 and \$20 per month.

The dairy at the present time supplies all of the milk needed at Fairmont. The poultry ranch supplies eggs and the hog ranch supplies all pork, ham and bacon needed. All these departments

will be developed to supply Arroyo Sanatorium and Highland Hospital, and this service can easily be extended to the entire group of county institutions.

A cost accounting system charging all expenditures, including interest on investments and depreciations, is kept for the farm. The farmer is notified in advance of quantities of farm products needed by the institution, is allowed current wholesale prices, and must run a paying business. As much produce is raised as the land and water available make possible.

The grounds are cared for by inmates under the direction of one head gardener. There is also a large greenhouse, where plants and flowers are raised for use in and around the hospital, and trees and shrubs grown for Highland Hospital grounds and all of the county institutions.

Laundry Is Important Feature

All mattresses used by the three hospitals are made and renovated by inmates. The shoe and tailor shops, conducted entirely by inmates, take care of all clothing and shoe repair work. The blacksmith, tin and machine shops, meet the need for mechanical work and repair of equipment. The carpenter, plumbing and paint shops, each under the direction of one outside employee, and manned by inmate helpers, keep up the maintenance and repair work of equipment and buildings. The power and refrigerating plants are operated by inmates, working under the direction of a chief engineer, with two assistants. A splendidly constructed and well equipped laundry, manned by inmates under direction of one head laundryman, does all the institution work amounting to over 200,000 pieces a month.

There are many activities in addition to those listed, and a large number of inmates are employed in the conduct of the institution as gatekeepers, ward porters, messengers, and in general work. An average of 58 per cent of the men in the home have been employed daily, 5 per cent being constantly off duty for temporary disabilities, leaving 37 per cent listed as totally disabled. Women are also given employment, as assistants in the women's department, repairing linen and clothing, and as waitresses in the women's dining room.

To meet the needs of this group of 37 per cent unfitted for active employment, and the chronic patients, a "community shoppe" was organized. This is under the direction of a trained occupational therapy teacher. The aim is to provide an interest in life through occupation, by teaching basketry, weaving, matting, brush making and various kinds of hand work—knitting, crocheting,

tatting, embroidery, and such things as can be done without much physical effort. The funds for starting this work were derived from the small profits earned by the cooperative canteen. The articles made are sold, one-half of the sale price being given to the inmates for this labor, and the other half paying for the materials and time of the instructor.

Articles Have a Ready Sale

The work is done in wards and in workshops. The articles made are principally such as have a ready sale, such as flower baskets, wood baskets, waste baskets, ferneries, magazine stands and brushes. Tin cans from the hospital kitchens are being used for making containers for the baskets. The sales of this department amount to about \$300 per month. Recently one order for 10,000 baskets was filled.

The response of the patients and inmates has been very fine and their cooperation general. The attitude of some patients and inmates has been changed from one of complaint and dissatisfaction to one of cooperation and boosting, as is illustrated by the following case:

A chronic tuberculosis patient, who was dissatisfied to the extent of complaining to the State Bureau of Tuberculosis, county officers, and the commission, responded actively to the invitation to do this work. Recently he headed a movement among the patients to give some token of appreciation to the superintendent and medical chief in acknowledgment of the fine service that the hospital was giving the patients.

Only patients and inmates who are unable to do general work of the institution on account of being crippled or suffering from chronic heart disease or other diseases, are employed in this department. It is the aim to give some occupation and interest to all inmates who are able to do even the simplest tasks.

Few Rules Are Established

To make the inmates as happy as possible and to develop an esprit de corps, every effort has been made to minimize the institutional side and to develop as nearly as possible, a normal community life. There are no set printed rules regulating the inmates' conduct but the ordinary rules of good conduct are observed.

The inmates sleep in dormitories but during the day most of their time is spent outdoors. For evenings or bad weather they have a living room adjoining each ward, and a pleasant library in which to gather.

The dining rooms are pleasant, with linoleum on floors, individual chairs, and a place assigned

to each inmate. The meal hours are practically the same as those of the employees, and menus are varied as much as possible.

Recreation is provided by weekly moving pictures and other entertainments and religious services. Current magazines and other reading matter as well as radio and phonographs, are provided.

A cooperative canteen, selling tobacco, candies, ice cream and soft drinks, is maintained by inmates under the direction of the steward.

Working clothes are supplied by the county. Interested friends and organizations supply other clothing which is cleaned and maintained by the tailor shop. An effort is made to supply all inmates with decent clothes for use on Sundays and holidays.

During work days inmates are not permitted to leave the institution except in case of special

need. Saturday afternoon, Sundays and holidays they may come and go as they wish.

Personal cleanliness is required. Inmates may bathe as often as they wish, but must do so at least once a week. Record is kept by an inmate in charge of the bath house and anyone who fails to comply with this rule is reported to the steward. A barber shop is maintained, and each man is given one hair cut a month and one shave a week. If he desires it oftener, he must pay for it.

Fairmont Hospital is designed to provide for the poor who are suffering from chronic illness, a hospital where they can be given necessary physical and medical care at proper cost; for the indigent aged and handicapped, a home with pleasant surroundings, clean comfortable living quarters, good food and care, as well as an interest in life and means of earning their maintenance.

AT ARROYO THE TUBERCULOUS GET WELL

By Chesley Bush, M.D., Medical Superintendent, Arroyo Sanatorium
Livermore, Calif.

ARROYO Sanatorium dates back to the passage of the tuberculosis subsidy law by the State of California. This law was passed in 1914. By it the state definitely abandoned the policy of caring for tuberculosis itself, and delegated that work to the various counties. The state agreed to subsidize any county maintaining a sanatorium which came up to state requirements. This subsidy was set at \$3 per week per patient.

The county of Alameda immediately saw where it could not only improve the care of its patients,

but obtain state money by so doing. This was the inception of Arroyo Sanatorium, the first new state subsidized county sanatorium. Alameda County chose as a site for this sanatorium a tract of land in the Livermore hills, forty miles east of its principal city, Oakland. This tract was chosen not only for its dominating situation as to view, but because the climate of the Livermore valley is more beneficial for bronchial troubles than that of the San Francisco Bay region where the major part of Alameda County lies. An intervening



One of the dormitories, Arroyo Sanatorium, Livermore, Calif.



Above, a general view of the adult dormitories; on the right, the children's building; below, the back of one of the dormitories.



range of hills separates the Livermore Valley from the bay, and within the valley there is much freedom from fog, much less humidity and an annual rainfall of half proportions.

The sanatorium opened in February, 1918, with a capacity of ninety patients and has been growing ever since. At present it has a capacity of 190 patients, of whom 150 are adults and forty are children—the children being housed in a separate unit. There are ten separate buildings including housing for the employees and all are served from one main kitchen. Diet kitchens are provided for the separate units. The service of food to the nearest diet kitchens is by hand, to those farthest away, by Ford truck.

Cafeteria Service in Force

The culinary department for the patients is operated on the cafeteria plan. Those patients who are able to go to their meals enter the service building hallway, where they receive trays and wrapped knives, forks and spoons. Then, passing along a steam table in the service room, they pick up their food just as in a city cafeteria, and enter a dining room. There they are seated at small tables, four to a table. On passing out they leave their paper napkins in a special bag kept for that purpose at the doorway. This bag is afterward taken to the incinerator by one of the patients. Those patients who are not temperature free and who are not allowed to go to their meals are served from diet kitchens, one on each floor of the infirmary building, and one in the north dormitory building. The cafeteria plan has proved cleanly, feasible, attractive and labor-saving.

Adequate Fire Protection

The sanatorium has its own water supply drawn from the gravels of a near-by creek and stored in two large 100,000-gallon concrete tanks, well above the level of the buildings. In addition to this, fire protection is given by the installation of six-inch mains with fire hydrants around all buildings. There is also an automatic fire pump which maintains a high pressure in all fire mains—and it is safe to say that the sanatorium has a better fire protection system than the average small town. All employees are subject to fire drill. There is an electrical fire alarm system, with a mechanical emergency substitute, and all fire alarms are reported to the neighboring city of Livermore. From there a fire engine and company of fire fighters can be on the scene within a few minutes.

There is a complete system of sewage disposal with a gravel filter bed and septic tank. In addition there is a separate incinerator house for the burning of dry garbage and infectious material.

Hot water and steam are obtained from a large boiler room containing two large 100-horse power boilers. These supply all buildings with the exception of several on the farthest part of the grounds, which have a small apartment house steam plant of their own. The water used by the boilers and all water in the domestic lines is softened. Electricity is supplied from outside connections and is the sole source of heat in the diet kitchens. The main kitchen uses distillate in its range.

Patients are admitted into the main infirmary building where there are a number of private rooms opening onto porches, and where there is a nurses' call system. Nurses are on duty day and night. Here also the sickest patients are kept. There is no discrimination as to the allotment of rooms. They are used exclusively for those patients who need them most.

As soon as a patient improves sufficiently to begin a small amount of exercise he is moved into one of the dormitory buildings. These are built on the ward plan with large wards, but an effort has been made to overcome the detrimental effect of large wards on tuberculous patients by installing partitions, thus breaking up the continuity of the line of beds.

All Rooms Are Airy

All rooms for patients, both in single rooms and wards, are made as open as possible, with all openings screened, while around the entire building are wide, open, covered porches with canvas awnings or drop curtains for use in stormy weather.

The children have a building of their own. This is at the farthest end of the grounds so as to be as far away as possible from the adult patients. It is maintained by a separate staff and has no connection with the rest of the institution save through the heads of departments. The food for this building, however, originates in the main kitchen. A school is maintained in the building.

In order to handle tuberculosis efficiently, Arroyo Sanatorium is linked up with a county wide tuberculosis program. This program has its beginning and ending in the lung clinics of the various health centers. The larger cities such as Oakland, Berkeley and Alameda maintain large clinics and the smaller cities maintain health nurses. Those near the sanatorium use the sanatorium as a clinic.

When new cases of tuberculosis are found in these clinics, they are listed according to the classification adopted by the National Tuberculosis Association, and if they fall within the "incipient" or "moderately advanced" groups, they are recom-

mended for admission to the sanatorium. If they appear to be advanced chronic cases, or cases that seem to have little hope for recovery, they are recommended for admission to the tuberculosis wards of the Fairmont Hospital, San Leandro, where beds for approximately 100 tuberculosis cases are maintained. There is a constant interchange between these wards and the sanatorium so that patients who offer further chance of benefit from sanatorium care, in spite of clinic prognosis, may be later transferred to the sanatorium. In like manner, if patients remain at the sanatorium for a long period without showing any prospects of the disease becoming arrested, they may be returned to the Fairmont Hospital, which is for custodial care only. Because of this arrangement, the sanatorium group is constantly being renewed, and the institution is used at the highest efficiency. The average stay of a patient at the sanatorium is thirteen months.

Individual Attention Is Given

Every effort is made at the sanatorium to study each case individually. When the disease becomes sufficiently arrested to warrant the beginning of exercise, various occupations are furnished. In these activities, the patients may work from one to eight hours, depending upon the individual's condition. As soon as they reach a working efficiency sufficient to maintain their economic status on the outside, they are discharged.

In addition, an extensive occupational therapy

department is maintained. Moreover, the patients carry on the post office, the canteen, the telephone, the radio, the newspaper service, and assist in the laboratory, ultraviolet room, in the office, and in other departments. An extensive library service is carried on for all patients, and weekly moving picture entertainments for those able to attend. From private sources, funds are provided to buy books and correspondence courses for patients who wish to study during their term of residence.

In order to educate the patients regarding tuberculosis, literature dealing with the care and prevention of this disease is given them, supplemented by radio talks. The beds are connected with a central receiving station so that instruction and entertainment can be relayed to bed patients.

Occupational Therapy Featured

An important feature of the work at Arroyo is the occupational therapy department. This was started at the instance of the California Tuberculosis Association, which supplied a teacher for the greater part of the year. Patients are taught to keep their hands busy and their minds occupied and they produce various articles of practical and artistic value. These articles are sold, 50 per cent of the selling price going to the patients. The balance of the money is used for the purchase of materials, making the department pay for itself. The work has psychologically been of great benefit to the patients, and the articles made have an intrinsic value and have found a ready market, in



The recreation room, where the occupational therapy work is done



The main infirmary building

fact, there are always orders waiting to be filled. This creates more enthusiasm among the patients and acts as an incentive to continue effort.

The classes are held in the airy, sunny, recreation room. The tables have homemade baskets on them, filled with flowers and there is a cheerful atmosphere about the whole setting. The classes are of one-hour periods, as pupils are not permitted to work beyond one hour, except when specially permitted by the medical director.

The recreation room is a real amusement pavilion, and a moving picture show, for which films are supplied free by the county, is a regular weekly program. There is a piano, a phonograph and a number of card tables, and amateur entertainments are brought out from Oakland at various intervals during the year. The advent of radio has been a great boon. In the January, 1926, issue of *THE MODERN HOSPITAL*, a brief description appeared of the radio apparatus that has been installed at Arroyo, which is operated by the regular telephone exchange workers as part of their daily task.

To keep up the morale of the patients and stimulate outside interests, a little monthly paper

called *The Stethoscope* is edited and published by and for the patients. This has a wide circulation among tuberculosis institutions throughout the United States and Canada. In addition, it has a decided local value to tuberculosis patients in Alameda County. Its monthly circulation approximates one thousand copies and it is frequently quoted in other publications. The newspaper office is on the ground floor of the south dormitory building and is a busy place. An electrically driven printing press has been installed.

Shop on Wheels Is Novel

A cooperative canteen shop on wheels is another novel feature that forms an interesting occupation for many patients and gives complete experience in operating a retail business, from the buying and selling to the keeping of books, as it is run by the patients in every detail. The "San Shop" as it is called, consists of a series of shelves arranged one above the other so that the contents are well displayed. The shelves are filled with candies and diverse notions which are in demand by patients. The movable shop began in a small way, with a few candies and notions requested by

patients, and has developed into a large business. The patient-manager is allowed a salary in proportion to the number of sales.

The shelves of the shop are put together rigidly and mounted on ball-bearing, rubber-tired wheels. The movable display case is fitted with samples of the merchandise that is carried in stock. The shop can be wheeled into patients' rooms and travels from floor to floor on the elevator.

In the children's department a school is operated, a teacher being supplied by the neighboring school district of Livermore. All children receive instruction in their various grades. School periods are arranged according to the physical condition of the child. Even orthopedic bed patients receive some bedside instruction.

Individual medical attention is given each of the patients at Arroyo, from the time of admission into the infirmary building until their discharge, and even afterward. As the physical condition of the patients improves within the institution, they are transferred from building to building until they reach a dormitory where no bed patients are kept and all must go to their meals.

Medical consultation service is obtained by the regular visits of an orthopedic surgeon, a pediatrician, and other consultations are obtained, when necessary, with the visiting staff of other county institutions.

Follow-up Clinics Maintained

Patients, upon discharge, are referred back to the clinics from which they originated, with instruction as to what their immediate routine should be. The sanatorium staff itself maintains two discharge follow-up clinics in the City of Berkeley, one for children and one for adults. The children, upon discharge, are usually sent to the preventorium before readmission to their homes. If patients express a desire to make a trip to the sanatorium for consultation, they are always encouraged to do so.

The policy of maintaining a separate hospital for advanced and chronic cases has proved well worth while. It has given the sanatorium opportunity to focus its attention on the rehabilitation of the tuberculous. It has also given the general public a hopeful attitude toward tuberculosis as treated at the sanatorium, and has stimulated patients to go to the sanatorium in stages of the disease when most can be done for them. It has also been a money saver, in that patients can be cared for at Fairmont Hospital in conjunction with the county infirmary at a cheaper rate than at the sanatorium, and this has also allowed the sanatorium a quicker turnover of patients, so that more persons can avail themselves of its valuable opportunities.

HOW THE VISITING NURSE SERVES THE SICK

A brief account of the work of the Oakland Visiting Nurse Association, Oakland, Calif., is appropriate at this time as a corollary to the detailed account given in this issue of the general health and hospital system in force in Alameda County, California.

Although the Oakland Visiting Nurse Association is not a branch of the Public Health Center of Alameda County, the activities of the two organizations are closely interwoven and their headquarters are in the same building—the Ethel Moore Memorial Building, Oakland, which also houses other health organizations of the county.

The medical director of the health center is also the medical director and member of the executive council of the Visiting Nurse Association board. This board is composed of seventeen members who meet once a month. All matters of importance in connection with the association are brought to the attention of the board.

The Visiting Nurse Association was organized in 1923 with three staff nurses. There are now eight staff nurses and one nurses' director. Each nurse is a registered graduate nurse and is trained to give skilled bedside care, and to instruct patients in the principles of healthful living and personal hygiene.

Aims to Give Skilled Nursing in Homes

The aims and purposes of the association are to give skilled nursing care to the sick in their homes, incorporating into the visit the teaching of personal hygiene and sanitation. Visiting nursing is one phase of public health nursing that includes bedside care.

The visiting nurse gives a part-time service, the patient receiving the attention that his case requires and paying for that attention on the basis of the cost per visit. Those who cannot meet the full cost are allowed to pay according to their circumstances. The scale may be sliding and financial circumstances determine the amount of the fee asked. The maximum fee for a nursing visit is one dollar; visits by special appointment, two dollars.

The care given is always under the direction of the family physician. The nurse will make frequent visits to expectant mothers and, directed by the physician, will give the necessary instruction in diet, rest and proper clothing. After confinement, the nurse will give nursing care to the mother and baby.

Not only does the visiting nurse give care to the sick individual of the family, but through her intelligent understanding of social and economic situations, she may help to unravel problems that are the cause of the illness.

It is the visiting nurse who interprets in simple terms to the mother and housewife the importance of immunization, the control of communicable disease, the importance of early training in health habits and the well balanced diet. These can be taught in almost any home. The visiting nurse must put into her visit a great spirit of friendliness in order to accomplish the greatest good. She should always be a welcome visitor in homes of both rich and poor, of all creeds and colors. Her district should be so organized that close relationship exists between her and other public health workers, parent-teacher associations and schools.

The Visiting Nurse Association is an agency of the Oakland Community Chest, an annual budget being received from that source. Other sources of income are contract work and fees from patients. The director of the nursing service welcomes opportunities to come before clubs and other public gatherings to bring to the attention of the public the work of the association.

Del Valle Farm and Its Children of the Sunlight



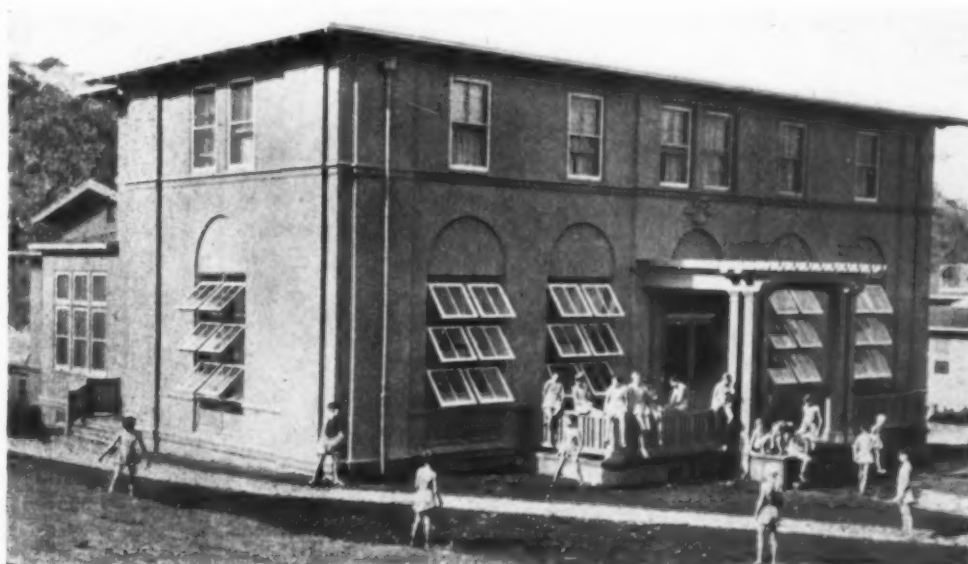
A LITTLE group of buildings nestling among the foothills of Livermore, with a fairylike setting of blossoming almond trees—such is Del Valle Farm in the springtime.

There sunshine tans the bodies and sunshine warms the hearts of fifty youngsters, members of the Del Valle Farm family. From dingy tenement homes come many of these children and at Del Valle make their first real acquaintanceship with the outdoors. Life on this farm is spent entirely in the open, with the kindly, healing rays of the sun as their closest companion.

The first goal of newcomers at Del Valle is to

attain a sunshine suit. This suit is made of a happy combination of Nature's tan and of a cotton material of neutral shade, scarcely as beautiful but not far off the natural tan of the skin. For the boys a sunshine outfit consists of a pair of cotton bloomers and some sandals, worn over a delicately browned skin. The girls, in addition, have a low cut bodice, with straps that cross in the back and button on the belt, not unlike the bodice of an ultra-fashionable evening gown.

Naturally one does not don the sunshine garment upon admittance to Del Valle Farm. There is a brief probationary period when one prepares



*Service building,
Del Valle Farm,
Livermore, Calif.*



The first unit of Del Valle Farm



The recreation room, which was originally used as a schoolroom



Here the children are shown caring for their pets



The library and recreation room, showing the radio



oneself for full-fledged membership in the Sunshine Order and its habiliments. It takes three weeks to earn a sunshine garment. On the first day a small portion of the body is exposed to the sun for five minutes. Each day an increasingly larger portion is exposed until at the end of three weeks the body has received a coat of tan sufficiently protective to permit the wearing of the farm regalia. From that time on the little patient is brother or sister to the rest of the family, not only under the skin but of the skin.

But how do these twenty-five boys of from six to twelve years of age and the twenty-five girls of the same age gain admittance to Del Valle Farm

'Way in the country!—where
They's ist but woods—an' pigs, an'
cows

An' all's outdoors an' air!—
An' orchard swing; an' churry-
trees—

An' churries in 'em!—Yes, an' these
Here redhead birds steals all they
please,

An' tetch 'em ef you dare!—
W'y wunst, one time, when we wuz
there,

We et out on the porch!
as James Whitcomb Riley has written.
To learn this we must review a little

history, but it is health history and should not be dull. This cheerful home for fifty happy youngsters is a main branch of the work of the Alameda County Tuberculosis Association, and is in a measure an outgrowth of the summer camps first established by the association in the summer of 1916, and continued until 1922.

These summer camps provided a month in the country for approximately 150 boys and girls who were underweight and undernourished, the children being boarded at a farm rented for this purpose by the association. The running expenses for each season were about \$2,000, and at the end of the summer, stakes were pulled up and nothing permanent remained, so that a fresh start had to be made each year.

Then the tuberculosis association planned a better way to provide a life-saving station for the school children of the county, and in 1921 purchased a forty-five acre farm in the Livermore Hills, having assigned for this purpose a sum of \$12,500 from the proceeds of its annual Christmas Seal Sale for the year of 1921.



Girls taking sun treatment on the porch

It is situated about three miles from Livermore, adjoining Arroyo Sanatorium. The situation is admirable, sufficiently retiring but accessible; the climate is warm, healthful and bracing. The farm includes forty-five acres of sunny hillside and pleasant valleys with beautiful views facing Mount Diablo. Its proximity to Arroyo Sanatorium enables it to share in the advantages of that finely equipped institution, so ably conducted by Dr. Chesley Bush and his trained medical staff, who are the medical supervisors of the farm.

Del Valle Farm might have been more correctly termed Del Valle Preventorium, but what a vast difference there is between going to a farm and going to a place where disease is prevented. And what farm product is there more valuable than happy, healthy human beings, such as Del Valle is able to turn out?

If anyone should dare to insinuate that Del Valle is not a real farm, any one of the fifty little sunshiners has evidence to the contrary. For Del Valle has pigs and Del Valle has ducks, and to visit Del Valle is quite as good as to visit the animal fair—all the birds and the beasts are there.

There are wire pens in which are cunning rabbits and guinea pigs. There are huge cages for pigeons and doves and even talkative parrots, all red, green and yellow. There is an animal house containing hogs, handsome, clean, non-tuberculous hogs. And then, of course, it could not be called a farm without a dog, and there are several dogs to follow small masters, lick their hands and gaze at them with adoring eyes.

Lightning and Rightstart are the farm's donkeys, the latter having been named by a little girl who felt that, like herself, the donkey was getting the right start in life by being privileged to live at Del Valle.

The children take entire care of the animals, each day certain children having the privilege of being assigned to the task. The boys look after the pigs and donkeys and the girls bring fresh crisp vegetables for the rabbits and guinea pigs, learning valuable food lessons at their tasks.

It was in 1923 that the first permanent building of the farm was erected. It consisted of two dormitories and a large open-air schoolroom, presided over by a certificated teacher. The schoolroom has since become a recreation hall. It contains the children's books, with reading tables, benches and comfortable chairs. A branch of the county library supplies books three times a week. A radio is a part of the

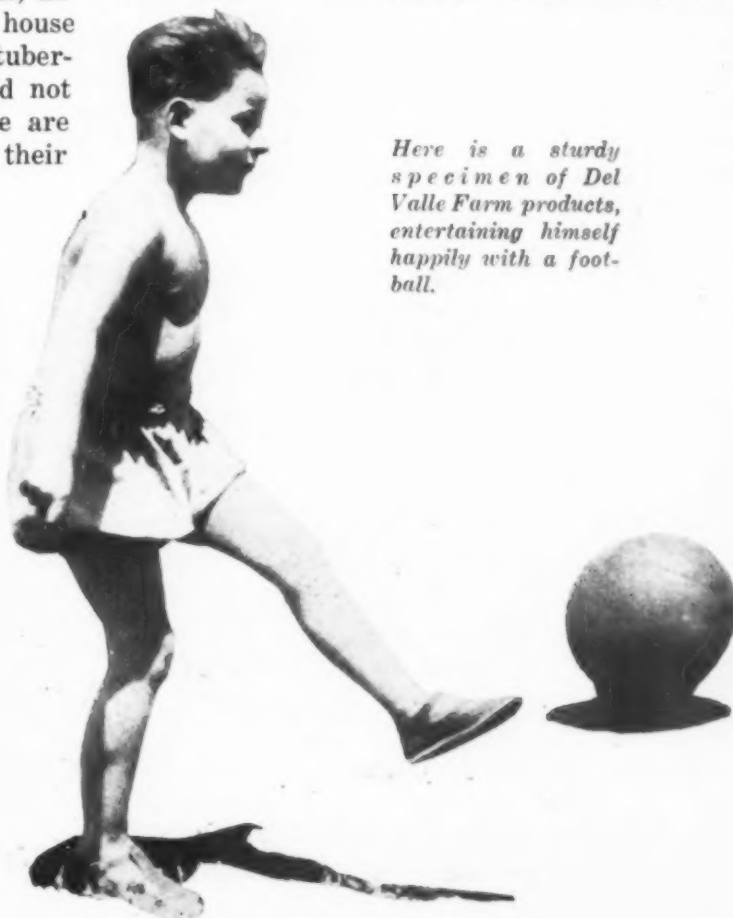
equipment, and all the children listen to a radio concert each evening before going to bed at seven o'clock. Funds from the 1922 and 1923 Christmas Seal Sale paid for the construction and equipment of this first unit.

In 1924 a service building was erected and equipped. This consists of dining rooms and kitchen for the children, and six bedrooms for women employees. The dining rooms and kitchen have been built with an eye to the future and are large enough to serve the home when additional dormitories have been added. This will be done as soon as possible for there is now a waiting list of proportions considerably larger than the total number now accommodated. The service building is a separate unit and is situated behind the original building.

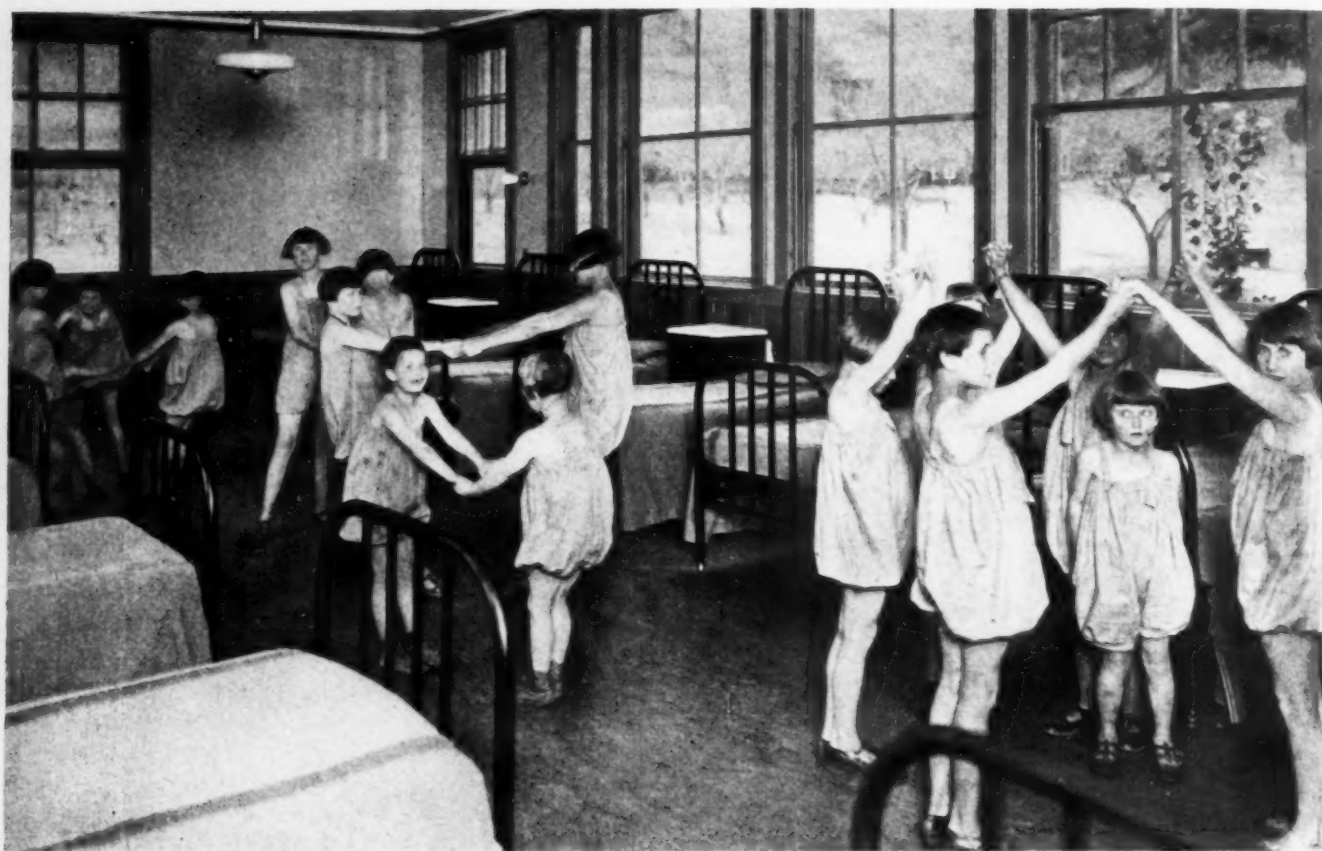
Another separate unit is the charming little open-air school, a Christmas gift to the farm from a generous friend of the children.

Another Christmas gift was the outdoor swimming pool, in the sun-warmed waters of which the children disport themselves gaily. Extensive playgrounds, orchards and numerous shade trees add to the joys of farm life.

An employees' building is now in course of construction and will provide sleeping accommodations for the nurses and other personnel who are now housed in temporary frame bungalows.



Here is a sturdy specimen of Del Valle Farm products, entertaining himself happily with a foot-ball.



Play hour in the girls' dormitory

The running expenses for this preventorium are provided by the community chests of Alameda County. These funds, however, cannot be used for building or equipment and the Christmas Seal sales have built and equipped Del Valle, unit by unit.

The children are selected by school nurses and

at the health centers, after medical examination reveals the necessity for care. They are the children of parents who cannot bear the extra financial burden of ill health. The age limits are six to twelve years inclusive, permission being given in special cases for children up to fourteen years, the decision in these cases resting with the social



The open air schoolroom



Group 1. Those who have been patients at Arroyo children's building (not open cases) and who, in the judgment of the medical director, should be sent to Del Valle.

Group 2. Children with or without known tuberculosis infection, manifesting one or more of the following symptoms: Continued loss of weight; consistent afternoon temperature of 99.6; malnutrition, but whose symptoms are not sufficiently definite to warrant admission to Arroyo.

Group 3. Children remaining 15 per cent or more underweight, after all apparent causes of this condition have been removed.

The social eligibility of the children is determined by the social service department of each health center according to the standards of eligibility for admission to clinics in use by the County Agencies Clearing House.

The county superintendent of schools has made Del Valle a school district and two regularly certificated teachers conduct classes in the open-air schoolroom, a cheerful and informal room with gay prints and pretty low round tables and chairs, painted in a shade of apple green. Thus children who are at Del Valle do not fall behind in their school work during their stay at the farm.

Manual training is especially emphasized and

service department of Alameda County Public Health Center. No actually tuberculous child is admitted. The physical eligibility of the children is passed upon by a member of the tuberculosis staff of the Alameda County Public Health Center, according to the following standards:

outdoor crafts are taught. Swings and sand-boxes are among the play equipment provided for the younger children, and the older ones have organized games such as basket ball, volley ball and hand ball.

The daily program is as follows:

7:00 a. m.	Call to "get up."
7:00- 7:30	Washing and tooth brush drill.
8:00- 9:30	Caring for pets, games, etc.
9:00-12:00	School for one group.
9:00-12:00	Other group, recreation, hikes, fishing or occupational therapy.
12:00-12:30	Rest on bed.
12:30- 1:00	Dinner.
1:00- 4:00	School for group not at 9-12 session.
1:30- 3:30	Sleep, for those not attending forenoon session.
4:30- 5:30	Shower baths.
5:00- 5:30	Listening in on radio.
5:30- 6:00	Supper.
6:00- 7:00	Radio concert.
7:00 p. m.	To bed.

When the children first come to the farm they are kept entirely in bed for two weeks. Then they have one hour of school work, then one hour of play and the sun treatment takes one hour. One



hour is spent at each of the three meals, and the children rest from one o'clock until three. Healthful ways of eating, sleeping and living are observed and taught at all times. The average gain in weight is two pounds per month.

Each child has a locker in which he keeps his wardrobe, consisting mainly of a sunshine suit, and his especial treasures.

The children remain at the farm until broken health has been built up, and the tendency to tuberculosis warded off—in other words, until they are completely restored to sound health.



ARE OPPORTUNITIES FOR FULLER SERVICE BEING WASTED?*

By Joseph C. Doane, M.D., Medical Director and Superintendent, Philadelphia General Hospital,
Philadelphia

THIS is an age of paradoxes. We are urged to economize in our personal and governmental lives, and yet at the same time we are spending more money, more time and more strength for pleasure, for luxuries, for the refinements of living, than ever before in the history of this country.

Now, when a paper on "Waste" is announced to a hospital audience, it is expected that the time-tried subject of methods of saving food, gauze, linens and the one and one hundred other items for which the hospital expends the public's money, will be discussed. But there is such a thing as saving at the spigot, and wasting at the bunghole—hoarding in small and inexpensive details, wasting larger and more costly commodities.

What is more priceless and passing than time, than opportunity to preserve and lengthen human life, than the chance to be of a fuller service to others?

So I wish to depart somewhat from the usual and to discuss the waste of the above mentioned commodities, though they are more abstract than hospital instruments and supplies and therefore perhaps more difficult to preserve.

Not all of the extravagances in the use of time and opportunity occur in any one hospital on any one day or in any one year, but all of them in some measure exist in our country's institutions at some time.

What Happens When Patient Becomes Ill

Let me mention some of the difficulties that may be presented to a patient when he becomes ill in his home.

J. M., age forty-five years, a salesman by occupation, with a family consisting of a wife and four children, and an income of thirty-five dollars a week, becomes ill in one of our large cities. He has not been a resident of this city long enough so that he can be said to have had a family doctor. He is at a loss to know whom to call. His illness was stormy in onset, and is of such a nature that early surgical intervention might be necessary. His wife, from the nearby drug store, calls a physician recommended to her by the druggist. The time being immediately before noon, she is informed the doctor cannot be reached for a num-

ber of hours. She at last secures another physician who promises to come and see her husband. He arrives in an hour.

He is not on the staff of any of the large public hospitals, but while he realizes that the patient should be immediately transferred to such an institution, he must endeavor to secure admission over the telephone. After trying four hospitals, each one of which informed him they had no vacant bed in the men's surgical ward, he called up the fifth institution. After a considerable delay he was connected with the superintendent's office and was informed that the superintendent was too busy to talk to him immediately but would shortly. In the meantime, the telephone operator spoke those words, which to some of us appear to justify murder, "Number please," which meant he was disconnected. He again got the hospital, and after a long wait was informed that the chief resident physician, the person whom he should ask for admission, was making rounds with his chief.

Is There Undue Delay?

After what seemed a further interminable wait, the chief resident physician was located on the private floor, and agreed to send the ambulance, after taking the name and phone number of the doctor sending in the call, and mildly cross-examining the physician as to his diagnosis and as to his certainty that hospital treatment was needed.

In forty-five minutes, the ambulance arrived, and because the patient lived on the third floor, and did not have the appearance of a person who was seriously ill, the ambulance physician mildly insisted that he walk to the ambulance. The ambulance driver was smoking a cigarette, and as the vehicle proceeded the smoke accentuated the nausea which was one of the patient's symptoms.

The patient arrived at the hospital three and one-half hours after the physician had first been sought. Upon his arrival at the hospital the admission clerk insisted upon inquiring as to his income, the name of his employers, the number of his children and his ability and willingness to pay, although the patient was in great pain.

After an examination in the admission ward, he finally reached a bed in the men's surgical ward, but the intern it was learned, had gone to

*Read at the meeting of the Indiana Hospital Association, Evansville, Ind., April, 1927.

his supper. Thirty minutes later he was seen by the intern, who called his chief and informed him of the admission of the patient. The chief requested a full blood count and urinalysis, after which the intern was to report to him again by telephone. Forty-five minutes later, the chief was again notified that the white blood count was 20,000. The urine contained a trace of albumin. The chief ordered the operating room to be prepared for an operation one hour later, and the patient's appendix was removed, approximately six hours after his condition was first recognized.

Now you may say this is an extreme case. Situations of this sort are happening daily. They represent the loss of valuable time, as well as of the opportunity to return the ailing man quickly to usefulness and the support of his family.

Central Referring Agency Needed

In no city of which I have knowledge is there a close enough liaison between the sick man and the available hospital bed. There is no central referring agency to which people may apply for speedy relief, and the likelihood of early entrance into a hospital depends upon the chance of securing a physician who has entrée to neighboring hospitals or who is actually upon a staff where a bed is available. Once an ethical wide-awake physician is secured, he will usually persist until entrance to a hospital is gained for his patient, but here enters again the problem of fitting the finances and social standing of the patient to the available bed.

In this instance, if our patient had been one who did not feel that he could use a ward bed but must have a semi-private or private bed, and if many ward beds were available but none of the latter classes, his hospital treatment would have been delayed even further.

I do not know of anything more exasperating than some attempts that I have made to gain entrance by telephone into some of the best hospitals of our country. Let us not forget that a visit to the hospital by telephone is one from which one gains favorable or unfavorable impressions of the hospital, its morale, its technique and its organization. Telephone companies speak of operators with "smiles in their voices." Such are of inestimable value when placed at our hospital switchboards, but they must also have brains back of their voices.

Again, some of our institutions have failed to systematize their methods of admission, so that really deserving patients are delayed in securing treatment, if not actually prevented from doing so. It is not always possible to have a well informed and authoritative person so located that

there is no delay in getting the proper information by telephone. The chief resident physician often is the admitting officer and must pass on the medical acceptability of patients, but he is not always easy to locate immediately, and in the meantime the inquiring physician who is often waiting in a stuffy telephone booth is either repeatedly disconnected from the hospital, or endures what appears to him to be an interminably long wait in securing the information which he desires. Some institutions keep what is known as a vacancy chart, showing the bed situation from hour to hour during the day. Some, I fear, reserve beds with the thought that staff members may require them, and thus prevent the fullest usefulness of the hospital's facilities to the community.

It seems advisable for the social history which is required on admission to be omitted in cases where an hour's delay may mean many weeks in convalescence. I know of a distinguished physician who applied for admission to one of the best hospitals in my city, and who, although suffering with pneumonia and with the exquisite pleuritic pains which often accompany this disease, was put through a cross-examination as to who made his private room reservations and as to his ability to pay therefor. If this is not indelibly stamping the dollar mark on hospital service, it approaches the cold commercialism that characterizes business dealings of today.

Would Standardized Laboratory Work Help?

Many hospitals are convinced that to possess a standardized list of laboratory procedures which are carried out upon the admission of any particular type of case, saves time for the hospital and serves to hasten the inauguration of treatment. In the instance cited above the intern should not have permitted hunger to delay for one moment the beginning of treatment, and when he had examined the patient and found the rigid abdomen and the history of vomiting which characterizes the onset of inflammation in the right lower quadrant of the abdomen, he should have immediately set about getting blood counts and urinalyses before calling the chief.

In this instance the physician was quickly located, but many institutions believe that the system of having one-half of its surgical staff on "receive"—that is, on continuous duty for twenty-four hours to answer emergencies—speeds up the surgical care of patients.

The exactions of private surgical practice, the one and a dozen different things to which the busy surgeon must attend daily, make it sometimes difficult quickly to secure the presence of a surgeon

or physician when he is needed in the hospital.

In this instance no delay was produced by an inability to secure the presence of a minister of the gospel prior to the beginning of the anesthetic, but not a few institutions have found that this, while an important matter to which attention should be given, is often the cause of delay in attending to the physical needs of the patient.

It may be added in regard to this specific case, that the hospital neglected to notify the referring physician that operation on his patient was imminent, and also that the wife of the patient was not present at the hospital because the admitting clerk had set down an incorrect address, and the message from the hospital was thereby delayed.

In this particular instance, too much time was lost between onset of the illness and that of the operation, and as a result, drainage was necessary, which prolonged the patient's stay in the hospital several weeks. The physician lost his confidence in the hospital and its methods because of the inconvenience he experienced in securing the admission of his patient, and because he had not been notified that an operation was to be performed immediately. Much distress was caused in the mind of the wife because she failed to reach the hospital before her husband was under the influence of the anesthetic.

Small things you will say. Yes, but they represent a series of lost opportunities to render speedy and efficient service to a sick man urgently in need of help.

Too Many Beds Are Vacant

Thirty-three per cent of the beds in the hospitals of this country stood vacant every day in the year 1925. This represented a total of 275,000 beds, or if each bed cared for two patients a month, a total loss of hospital facilities representing care to over 600,000 persons.

Can this often necessary vacancy of hospital beds be reduced? Patients could certainly be moved more rapidly if greater attention were paid to such details as immediately instituting treatment and making laboratory and x-ray studies as soon as they are indicated. How often do we learn that a certain x-ray picture has not been taken because the intern failed to fill out the sheet until the x-ray technician had gone home? A basal metabolic study is ordered, but some one forgets and gives the patient his breakfast and then another day is lost in the service which that patient's bed should be rendering.

A slip somewhere along the line of surgical technique produces an infection of the skin in what otherwise was a simple operation. Many days are lost which cost the hospital four or five

dollars each, and many other days are lost for the patient, during which his income is nil. It is decided to discharge the patient on the morrow, but the intern forgets to fill out his card until the morning discharge hour is past, and then it is discovered that his clothes have not been returned from home, and another day is lost to the hospital and the patient.

How to Help the Cardiac

This waste of time is not always seen at its worst in the matter of securing early treatment for the patient and his prompt discharge when relieved. There is the cardiac, who is admitted suffering with a decompensating heart which is manifested by greatly swollen limbs, panting breath and blue lips, and is slowly nursed back to comparative health through rest and digitalis. He is discharged from the hospital, but because he has not been advised to do otherwise he returns to his work as longshoreman. In a few weeks he is seen again in the hospital with the same symptoms, but in a more aggravated form than previously. There is no finer example of wasted time and opportunity than is illustrated by such a case. I have never been able to understand why we persist in painstakingly caring for the cardiac and then letting him undo all of our good works in a much shorter time than it takes to bring them about.

The hospital that does not earnestly endeavor to carry its principles and precepts into the homes and into the lives of its former patients is wasting much effort and time.

Good conscientious social service work we must have, and if these workers do not collect one dollar of board money for the hospital, but transplant and translate the principles of right living into the homes of the hospital's patients, they more than justify their existence. There is no excuse for the life of the cardiac cripple being quite such a round of admissions and discharges to and from the hospital as it is now.

I am of the opinion that it is a waste of time and effort to endeavor to enforce a rule forbidding interns from inviting nurses to accompany them to social gatherings. Many hospitals endeavor to enforce such a rule, but it seems much more reasonable and fair to these young people to permit interns to call at the nurses' home for student nurses, and in a perfectly open and above board manner accompany them to the theater or to other entertainments. I do not believe it is wise to have a rule that cannot be enforced and the fairness of which is somewhat in question.

In certain localities in this country there are surgeons who pride themselves that they may

safely get some of their cases, particularly so-called clean appendix patients, out of bed on the third day. This has always appeared to me as a case of haste making waste, because the heart muscle is distinctly poisoned by ether, and not a few cases suffer the ill effects of this rash procedure later in life.

There is also much waste in my institution, and I presume in others, of the dispensary patient's time. It is often difficult to open the dispensary at the hour set, and the patient must wait until he is called for treatment, even though he is losing money by being absent from his work. Often when he does reach the physician, he is examined in a cursory manner by an intern, well-meaning enough, but whose experience sometimes does not make it possible for him to render advice that is worth to the patient his visit to the hospital. I think sometimes we forget that it is the patient's time and health that we are endeavoring to save, and that time lost in securing medical attention is money which we are wrongfully extracting from the family's income.

Have Nurses a Grievance?

There is much being said nowadays concerning the waste of the nurse's time. I have recently been reading a report of a learned commission in regard to the nursing situation, and in the report I find a detailed statement of the number of hours lost by the nurse in performing what has been designated as non-nursing duties. For example: In the women's surgical ward, I read that in one day the senior nurse spent three, the second year student, three and one-half and the first year student, four and one-half hours in performing such duties as dusting, folding linen, carrying trays and making surgical supplies.

It is stated that "most of these duties are maids' work," which is, in part, true. It is also contended that it is an economic loss to allow the intelligent student nurse to perform duties that one of less training and intelligence might perform. And in the main this statement is true.

But I contend that the leaders in the nursing profession, by reiterating that certain services should not be required of nurses, services that the nurses will certainly have to perform in private homes where maids for economic reasons cannot be employed, are making it probable that nurses will resent being asked or required to do these necessary things. When we remember that 80 per cent of the population in the United States is neither rich nor very poor, and that a large percentage of the graduate nurse's time must be spent in the homes of these people, it becomes apparent, at least to me, that graduate nurses must dust

and carry food trays and even sometimes wash soiled linen, because there is no one else to do it and because the family purse is being taxed to the uttermost to meet her salary.

I do not wish to be understood as arguing for the exploitation of the nurse and her time in the hospital, but until some more equitable, economic adjustment can be made, hospitals must continue the system of endeavoring in the best way possible to care for their patients, and, at the same time, adequately educate the nurse. While I am a strong advocate of higher standards for nurses, I am a stronger advocate of better care of patients, and if higher standards for nurses will bring the latter about, and if the expenditure of money, if it can be secured, for more maids, will prepare women to care for patients better, then there appears to be no argument as to raised standards.

The most casual observer on his visit to many of the private floors of the hospitals in our country cannot but remark the beavies of graduate nurses that seem to have no more serious duty in life than the proper arrangement of snapdragons and roses. Here is a waste for which I know no remedy, and for which I do not believe a certain type of graduate nurse desires one. Certainly she would have to work harder if she were engaged in group nursing, and were required to care for four patients instead of one convalescent, although somewhat irritable woman.

We hear much said nowadays in regard to the scarcity of nurses, but perhaps the difficulty lies in the method of utilizing the present nurse supply rather than in the actual numerical insufficiency. I note that for the past three or four years there has been an increasing number of graduates registering each year.

Superintendents Waste Opportunities

Much could be said in regard to the waste of the superintendent's time and opportunities. Some of us, I fear, are of the type of organizer that allows himself to perform too many trivial duties while larger opportunities are passing. Are we consuming our time and energy in signing requisitions and in answering telephone inquiries while the relationship of our hospital to the community needs strengthening and its aims and ideals need interpretation? Is the hospital doing its part to add to the sum total of human knowledge concerning why people become ill, how and why they die?

I have been much interested in reading in the recent hospital number of the *Journal of the American Medical Association*, an article relative to the percentages of postmortem examinations that are secured in our country's institutions. Out

of 578 hospitals approved by the Council on Medical Education and Hospitals of the American Medical Association, 135 had a percentage above 50, 68 had a percentage between 30 and 50, 146 between 15 and 30, and 307 less than 15.

To me this appears to be an unsatisfactory showing and reflects upon the attitude of the hospital toward its contribution to medical education. It is encouraging to know that the committee to which reference has been made has decided that no hospital will be approved for internship after January 1, 1928, that does not have at least 10 per cent, and none after January 1, 1929, that does not have 15 per cent postmortems. But this should be the minimum, and I have often felt that no hospital should be content until at least one of every three deaths is brought to postmortem. A full realization of the hospital's obligation to its intern staff, to the community and to medical education as a whole, cannot but bring about a feeling that a valuable opportunity has been lost in not more strongly urging the importance of postmortems.

Research Should Be Encouraged

It appears that hospitals of whatever size are daily losing chances of encouraging research, particularly amongst the younger members of their staffs. It makes no difference whether the research be of major or minor proportions. If a better way can be found for dressing an ulcer of the leg, not only is the patient benefited but the hospital shares in the credit thus secured. In my hospital recently a worker has found an organism which he believes to be the cause of rheumatic fever. Whether or not this be true, and whether or not the possibilities of this discovery are ever realized, I cannot but note a speeding up in everything along investigative lines, and a rise in the morale not only in the laboratory but in the whole hospital, and so I say that we, as hospital superintendents, must encourage research.

And then, are we not losing opportunities to teach people about themselves and about the diseases to which they are liable?

In the United States, out of 6,946 hospitals, but 1,992 have out-patient departments. Here is the place where the education of the members of the hospital's community can best be carried on. Hospital wards are too busy and hospital personnel too hurried to supply good preventive medicine information during the patient's stay, but in a dispensary should we not be educationally more helpful? Should we not enlarge the scope of the out-patient work to include clinics for well people as well as for those who are ill? The occupational clinic which examines men and women to

learn what can be done to keep them well, which examines from a public health standpoint those who handle food, is of inestimable value to any community.

I wonder whether our hospitals have not been too long willing to be but repair shops for broken down humanity; whether our hospital vision has been so clouded by the task of getting sick people back to their daily work, that it has not seen that in one way only can we conquer disease, and that by prevention. To do our bit in preventing illness, we must be part and parcel of the community health program, the very hub of this activity, and as has been intimated above, a properly equipped medical social service department is of great value in bringing this about.

What Is Social Worker's Role?

Unless these men and women are concerned with the prevention and cure of disease, unless these workers are well trained to do their work, and to do it along preventive as well as curative lines, the hospital cannot do its part in achieving community health, for to speak of economy in the social service department where the prevention of disease should be paramount, and then to send out women who should be well paid, to locate a fugitive fifteen dollar board bill, does not appear to be consistent. The danger lies in not properly placing the social service department in our hospital organization, in not having it in close co-operation with the visiting and resident staffs.

In Pennsylvania in 149 hospitals receiving state aid (less than one-half of the total which is 364) there were almost 1,000,000 visits paid to the out-patient department last year, and nearly one-half million of these visits were made to seven teaching hospitals.

Systematize Dispensary Teaching

Those of you who have recently visited any of the localities where real estate booms are now in evidence, know that lectures, moving picture performances, barbecues and bus rides are given for the sole purpose of securing an opportunity to extol for a few minutes the value of real estate offerings. But at least in Pennsylvania where a million people visit the hospital dispensary during the year, of their own free will, I fear that many have, figuratively at least, gone away empty handed—no lasting, intelligent interest in their own health or in the community's health having been aroused by their visit. I see no reason why dispensary teaching should not be more systematic.

I do not understand why dietetic lessons and sewing lessons may not be given, particularly to

the prenatal patient; why informative tracts should not be distributed to the patients of the cardiac, metabolic, prenatal and postnatal clinics. I do not believe it would be impossible for young doctors or nurses with crayons, blackboard or charts more definitely to demonstrate why people become ill, and what can be done to avoid sickness. In but two hospitals in Philadelphia is any attempt being made to conduct what might be called well organized clinics for children of pre-school age. If you have ever visited a clinic of this sort, you cannot have failed to be impressed by the zest with which these little people enter into the health games and into the memorizing of health jingles.

Nor is the clinic devoid of opportunity for actually saving money. In a certain municipal hospital, which until recently always had from fifteen to thirty maternity cases awaiting delivery, a prenatal clinic was started. Home investigation, proper placement and other intelligent social service activities quickly reduced this waiting list from an average of twenty-five to eight or ten.

How much money did this clinic save the hospital in the course of the year, each patient's daily expense to the hospital being \$3?

Are We Training Interns Right?

And then I wonder whether our hospitals are not wasting opportunities in instructing interns. John Abernathy, the famous Scotch surgeon, once said that the hospital is the only proper college in which to train a true son of Æsculapius. It has been truthfully said that "as the young physician practices in his hospital, so will he practice medicine during his professional life." If this statement is true, it can be easily seen that the future of American medicine lies in the hands of the hospital, and that the intern deserves and must receive more than a casual training at the hands of the hospital's visiting staff.

And then I wonder whether we are not wasting the opportunity of exercising the humanities in the hospital. Does it not seem that some of our institutions are becoming too coldly efficient, too businesslike, too much like a great machine that expects to receive a grist of sick people, and by the mere revolving of wheels, to turn out a slightly diminished stream of well persons at the very end?

The English hospital possesses much of the homelikeness, of the intimacy that I seem to miss in my own and other institutions. Why do we awaken the patients at 5 a. m. to take their temperature and wash their faces? Do you know the jingle that goes:

"Who is it comes, a perfect pest, at 6 a. m. to

break my rest, disturbing me in my warm nest?—The Night Nurse.

Who, to remove superfluous dirt, a basin brings, and with orders curt, 'Sit up and wash, take off your shirt'—The Night Nurse.

Who goes when all has been put aright and leaves me grinning with delight, but dreading still the coming night—The Night Nurse."

With most of our patients, whether one or three degrees of temperature have been accumulated during the night, it would make no difference at six in the morning, so far as any immediate treatment is concerned.

Ofttimes I wonder whether the physician and the nurse and even the superintendent, are careful enough in their conversation concerning the patient's condition when within his hearing. I wonder whether we always realize that a bit of information that to us appears commonplace, may serve to confirm in the patient's mind those fears that have haunted him since he knew that entrance to a hospital was imminent and that an operation might be necessary.

The great Sydenham, whose name adorns the pages of so much of our medical literature, upon his death, was found to have inscribed in many places in his manuscript a scriptural verse which must have served as an incentive to greater medical effort on his part. We, as hospital administrators, have about us every day opportunities for the performance of fine services to humanity. Are we permitting the waste of time and of opportunity, and are we making the principle which was the golden rule of Sydenham's life, our aim: "Whatsoever thy hand findeth to do, do it with thy might, for there is no work or disease or knowledge or wisdom in the grave, whither thou goest."

HOW FAR ARE TRUSTEES RESPONSIBLE?

Commenting upon the responsibility of trustees in raising the standards of individual hospitals in this country, the *Journal of the American Medical Association* says in part:

"Hospitals have now reached a higher standard of development than ever before attained, but there are still further heights to which they may climb in their service to humanity. This further progress depends more on the intelligence, skill and high ideals of the physicians on the attending staff than on all other factors combined. It is of first importance, therefore, in the future of hospitals in this country, that no influence, either from within or without, shall be permitted to interfere with the high educational and moral standard by which hospital staffs are so generally selected. Hospital directors or trustees are morally, if not legally, responsible for the maintenance of such staffs, a responsibility that has been recognized by the courts in every instance in which their right to remove from, or to refuse admission to, the staff has been questioned."

HOW CONVALESCENT AND HOSPITAL CARE DIFFER

By Frederic Brush, M.D., Medical Director, The Burke Foundation,
White Plains, N. Y.

THE treatment of convalescents, and the allied sub-standard borderline classes, in country institutions is steadily developing in America (the census of 1927 shows increase of more than 5,000 convalescent beds alone in the past four years), and various new and distinctive public health and communal problems are being encountered. The recognition of certain approximate standards and precedents will be generally helpful, and especially so to those about to enter this field.

These institutions are either separate corporate organizations (the majority), or branches of hospitals or central agencies. This report applies principally to the first-named class; but the branches, which of course merge their management and responsibilities with the parent organization, may find herein many kindred applications.

The country institution's responsibility begins when the patient arrives at its admission office, or comes under charge of its representative elsewhere along the way of the admission process; under certain methods not until the patient reaches the home. Patients in transit out are usually placed under direction of some agent of the institution. Recovered and responsible adults are considered discharged from the home when they pass out of its gates, or are deposited at the station of a feasible transport line, or let off under regulation in suitable nearness to residence or destination. Children and those physically or mentally incapacitated for self-travel require escort until taken over by parents or caretakers at the other end; girls just under the "age of consent" are in some instances given like protection. The right of the home to discharge and escort from its premises any patient whose quarrelsome, violent or unfitting behavior is seriously prejudicial to the safety and welfare of others, is assured.

Only the general commercial and hospital standards of safety and comfort in transportation are

required, whether by motor car, railway or ambulance, with some extra attention to the weak and crippled. It is an established fact that very ill persons may be returned in ambulance considerable distances with safety, and with eventual benefit to them through placement under hospital care.

These country institutions are not obligated to have resident physicians, but where there are upwards of 150 beds, or less in certain special types, it will be generally advisable for them to do so. An attending physician, preferably salaried, making regular visits, at intervals adapted to the kinds of patients, etc., may well cover the requirements of the medium sized places, while even the smallest home should have an advisory medical staff, with local physician, and substitutes, on call for emergencies. The attending physician aids in determining admission, medical and sanitary policies, discharges and the treatment of the more serious ailments.

Resident or attending physicians will occasionally be called upon to do minor and emergent surgery and treatments, but any procedures beyond these are best met by transferring the patient promptly to hospital or equivalent care. Only a



Short golf course, laid out to provide moderate slope climbing, and requiring but little land.

minor duplication of hospital equipment is advisable for the country institution. Nurses and trained attendants are privileged to make such applications and treatments as are customarily considered as coming within their spheres. Surgical

dressings are properly done by a trained nurse—acting under the physician's general directions. Written or telephoned directions from the patient source may be taken advantage of.

Convalescent nursing differs from hospital or bedside nursing to a degree that makes it well-

provision of reasonable, standard supervision of all these prescribed activities, with assured safety of apparatus comparable to that in schools, playgrounds and gymnasiums is deemed sufficient. Certain classes, such as heart disease and orthopedics, need special oversight and direction. Prompt first-aid is here assumed.

Full dental service, or minor and alleviative which is the commoner practice, may be provided at the home, or by referring patients outside, yet still under the home's care.

Convalescents generally need but little drug therapy. Where such is clearly required the separate corporate home may well continue the sender's medication if instructions from the source are given in writing, and it accords with the home's judgment of needs under the rapidly changing conditions of the patients.

This applies also to surgical and other treatments. It is obvious, however, that the home must know of and control all therapeutic articles and practices coming within its service.

The convalescent institution will not introduce, knowingly, communicable diseases into the country community, or transfer them across governmental borderlines without sanction of the public health authorities concerned. It should provide for suitable temporary isolation, report and care of such cases whenever they may occur within the institution.

Building plans, water supply, sewage disposal and sanitary arrangements in general, and customs and methods for disease prevention and control, are necessarily made to conform to the demands of the local departments of public safety and boards of health.

Fire trap buildings and sections are still prevalent in convalescent institutions. Hospital standards of fire protection are to be adopted, especially in the case of made-over and non-fireproof structures. But most of the convalescent buildings are only one or two low stories in height, the inmates are mainly ambulant and fairly active, and frequent disturbing fire drills involving these short-stay and constantly changing patients are inadvisable. Exceptions are made in the case of long resident children. Posted fire rules with periodic instruction of leaders and employees, and standard fire fighting apparatus, generally prove adequate.



The institutional play fields are used for county league games.

nigh a special branch. A much greater proportion of undergraduate nurses and aids may be utilized. One nurse or skilled attendant to forty or fifty adult convalescent patients is adequate, except where special classes are admitted, and with infants and younger children who may require a ratio of one nurse to four or five children. Administrative heads are not here included. The larger institutions provide one or more night nurses, who make rounds in hallways and visit listening points at least once every two hours. The small homes have a nurse on night call only.

Reasonable day care is ruled to be much less closely personal and particular than that necessary for hospital patients. Active and trusty patients are frequently detailed, as part of their occupational therapy, and sometimes on a low wage, to report nursing needs or to aid in the care. In such cases they assume the obligations of regular employees. Nurse superintendents and nurse heads in these somewhat isolated plants are necessarily given unusual privilege and responsibility in applying drug and other therapies. It would seem best for them to have written, broadly covering, sanctions from their physicians or managers, wherever possible.

The country institutional regimen comprises increasingly the active recreational and occupational outdoor and indoor physical therapies, and various injuries, mostly minor, and frequently imaginary or feigned, are bound to occur therein. The

(The 1925 study, with recommendations, of the New York Convalescent Service is available and fully covers this question.)*

The convalescent home should be well protected by fire and certain kinds of casualty and transportation insurance, adapted to individual circumstances.

Insurance Carriers Should Pay Cost

Patients under workmen's compensation pay have been extensively given free care in convalescent homes. The aggregate value of such treatments already donated in this vicinity would undoubtedly run into hundreds of thousands of dollars. The opinion is gaining ground that the insurance carriers should pay at cost for such treatment, and two dollars per day, a fair average expense, is being charged in some convalescent homes, the insurance company approving the admission and reserving the right to decide term of stay, but accepting the home's treatment-regimen.

The increasing practice of city financial aid to convalescent institutions in approved cases, on a per capita basis, recognizes this branch as a desirable form of hospital extension and preventive public health work, and this support may be expected to grow gradually and be the subject of standardizations and agreements. In accordance with many decisions governing hospital practice, it is understood that convalescent homes may take pay for the care, without prejudicing their status as charitable institutions.

What Testimony Must Be Given

The medical and behavior records of convalescent patients are often demanded by the courts, commissions and beneficial organizations. Here the convalescent homes are upheld in giving only a certified copy of the treatment card or the court presentation of the original card record by an agent. For any further testimony as to diagnosis, treatment or prognosis, reference is made to the source of the patient and to those giving the after-care. Some homes aim to give no testimony, but refer all to the sending agency. The right of withholding privileged communications is evidently the same as with hospitals and physicians.

Practically all of the convalescent homes under consideration are classed as "charitable," go tax-free, and are located in the cities' outer borders or in adjacent suburbs, and occupy, in the aggregate, large areas of valuable land. Their relations, both welfare and financial, to the surrounding communities, are being increasingly studied and criticized. While the homes comprise as yet but

a minor portion of the total tax-free property under discussion, it would seem that the adoption of at least tentative standards of required land occupancy and of communal relations might valuably contribute to equitable future adjustments of this insistent tax abuse and community-detriment problem. One-fourth acre of land per patient bed, building sites included, is presented as a fair requirement for the conduct of successful country convalescence—the ratio, of course, justly varying somewhat for different classes of patients and kinds of care.

Reception of patients from the contiguous territory, and the measured use of the institutional grounds and equipment for outside communal recreation, will also go far toward establishing just and important governmental, public health and social relationships. It is to be noted, for example, that New York City is now going into adjacent states for some of its convalescent provision, and questions of jurisdiction and cooperation are bound to arise.

HOW SHOULD THE LABORATORY BUDGET BE DETERMINED?

One of the problems that arises in connection with the laboratory budget is whether or not it should be based upon bed capacity. The experience of several hospitals is that this method is not always satisfactory, since the class of patients differs in the various types of institutions and the amount and kinds of laboratory tests depend upon the number of tests per patient, the hospital turnover and the proportions of medical and surgical patients.

For example, it is not possible to estimate the cost of a laboratory for a tuberculosis sanitarium on the same basis that is applied to a surgical hospital. In the former, sputa may be examined satisfactorily by technicians while in the latter institution the majority of work falls upon the trained pathologist. Tissue sections can be prepared by technicians but tissue diagnosis can be done only by thoroughly trained specialists having both medical knowledge and laboratory experience.

The chief items in the laboratory budget include the salaries of the pathologist, assistants, technical employees, cleaning service and the amount for general expense. The last item generally amounts to 15 or 20 per cent of the amount of the salary budget. Where the laboratory pays for its own printing and repairs, this amount may be insufficient.

CONSTRUCTIVE PUBLICITY

The art of effective advertising lies in the use of photographs that tell a story without the use of a great deal of text matter. Such publicity has been used with success by a Southern hospital. Two pictures were used in each advertisement; one showing a group of doctors and nurses and the other a pleasant room in the hospital, with a nurse seated beside a smiling patient. The only text matter that was used were the words, "Always a faithful friend." The secret of the effectiveness of this kind of publicity is that it suggests health, happiness and comfort in a hospital rather than discomfort and suffering.

*Hospital Information Bureau, United Hosp. Fund, 151 Fifth Ave., New York.

REMOVING MENTAL HAZARDS IN THE GENERAL HOSPITAL*

By Sister M. Laurentine, St. Francis Hospital,
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IT SEEMS proper to infer that every general hospital includes among its patients some individuals suffering from functional nervous disorders, and indeed many of this group may be found in the surgical as well as the medical divisions.

With this fact before us we might ask ourselves, "Who is the nervous patient?" We are nearest to the truth if we answer, "Practically every one admitted to the hospital." To those of us who are daily seeing patients admitted and operated upon, the tragic side of this event, with its unhappy possibilities, does not loom up so ominously. When we consider the matter from the viewpoint of the patient, however, or when such a decision comes up in our own family, we realize the nervous strain associated with these occasions. It may be a gall bladder case or merely a tonsillectomy, yet there is usually present a state of anxiety and perhaps fear that is distinctly a neurosis, and that must be handled just as dexterously as any operative procedure. The influence of this reaction on the postoperative stage is a factor not to be ignored.

Consider Patient's Family

In addition to the emotional conflict in the patient, we are also frequently confronted with a state of demoralization in the family, which we must attempt to adjust if we are to get the best results. This may appear to be outside the pale of our duty, but we must remember that anything that conduces to the recovery of the patient is within the bounds of our responsibility. And we can readily understand the tension and anxiety of the family, if we consider that this experience is to them an entirely new one, and that the hospital presents many unfamiliar and formidable aspects.

On all services we may find, associated with definite pathological conditions, complicating nervous phenomena that require some special study and treatment. Every physician, general or special, should be sufficiently schooled to appreciate that practically all nervous disorders of a functional type are benign in their origin, and become chronic through the neglect of those whose duty it is to prevent as well as treat disease, and for

whose mistakes no valid excuse can be offered.

It is obvious therefore that we should look upon the nervous system in its intimate association with every organ in the body as a factor even in the disorders with definite pathology, and should recognize the value of establishing a proper control in this sphere as a step towards the ultimate recovery of the particular condition for which the patient enters the hospital. As much time as is required to handle this phase of the trouble should be conscientiously given to every case. Perhaps it seems absurd to expect the busy surgeon or internist to spend fifteen to thirty minutes talking to a patient, or listening to his difficulties, when there are so many urgent demands upon his time. I wonder how it would appear to any of us if surgical dressing, hypodermoclysis or gastric lavage were indicated, and the treatment were omitted on the plea that we were busy and did not have the time to administer the treatment. Such an excuse would certainly seem unusual, and these patients with neuroses are justly entitled to the time required for a mental lavage if that is the type of treatment necessary to adjust their particular problems.

As hospital workers we must endeavor to get the proper understanding of the neuroses. We must learn to appreciate the many traumatisms suffered by the nervous system and expend all the nursing skill necessary in its repair and rehabilitation. Quite frequently our patients have been practically dissected by the various special departments. They are told that their symptoms are due to gastric ulcer, or to visceroptosis, or perhaps a thyroid dysfunction with cardiac involvement. Maybe many other diagnoses are suggested.

Do Not Dwell on Symptoms

When the physical examination, laboratory x-ray and other data have been assembled, and no pathology is found, the impression is given that there is nothing wrong except an overstimulated imagination, and a diagnosis of some type of neurosis is made. Perhaps various treatments such as diet, glandular extracts, or other forms of therapy are administered with the feeling that something should be done for the patient. This attention to the symptoms only deepens the anxiety concerning them, and the neurosis becomes more profound. The patient then comes to

*Read at the meeting of the Catholic Hospital Association of Pennsylvania, Scranton, Pa., April, 1927.

the neuropsychiatric service, and not infrequently is unsuccessfully treated owing to the difficulties encountered in trying to break through his defense, built on the knowledge acquired concerning the somatic symptoms complained of.

This is not quite fair to the patient suffering from a neurosis. The fact that a comprehensive study revealed no pathology is not a positive indication of its absence. We all know of instances where a laparotomy, or sadder still, an autopsy brought to light some unsuspected lesion, a lesion perhaps not usually associated with the complaints enumerated, and not readily elicited by careful physical examination, yet producing its degenerating effects so insidiously as to present the picture of a functional neurosis.

The ultimate decision that a patient is suffering from a psychoneurosis is to the minds of many internists simply an indication that they have failed to make a diagnosis, and this is perhaps a truism inasmuch as even the purely functional group represent some dysfunction along the paths of the sympathetic nervous system, most likely an imbalance of the endocrine glands, or at least something that renders the individual unfit to make normal adjustments to unusual situations.

It is no doubt the unquestionable right of these patients to have a thorough physical examination, and any condition that might tend to lower resistance must be corrected. It would seem advisable to have the opinion of a competent neuropsychiatrist to establish the presence of a neurosis, and it really matters little to us what the particular type may be as our approach to it will not be altered.

Illness Is Not Imaginary

In the first place let us not throw up our hands and shrug our shoulders and in a hopeless tone of voice exclaim that "he or she is just nervous." The term "nervous" does not mean anything, and especially it does not mean that the patient has a tremor of the hands. More especially and more emphatically it does not mean that the patient is imagining his ailment and that he is a malingerer. One of the most important factors in handling a neurosis is the conviction in our own minds that the patient has a definite illness, not organic it is true, yet nevertheless an illness that is real and one that will recover if it be intelligently treated.

The theory that these patients all suffer from some conflict in the subconscious mind, and that the symptoms presented are an attempt to escape from the necessity of meeting this problem squarely, seems to those of us who are working in this field, a logical explanation for many of the complaints. My very limited knowledge of the

mechanisms of this theory precludes my making any attempt to elaborate on the subject; furthermore, I would thereby be within the confines of a branch of medicine, where of course I have no right to intrude.

The management of these patients is obviously the task of a competent physician, but, as much of the work is nursing we must understand something of the problem of taking care of them, if we are to be of assistance in this reconstructive work. It is the opinion of most of the men I know that nursing is important and lends much to the success of the physician's efforts.

Where to Handle Cases

Contrary to the opinion of some workers in the field, we feel that the place to handle the psychoneuroses and some of the mild psychoses is in the general medical ward. The segregation of these patients sometimes tends to the development of mutual sympathy and free retailing of complaints, which is a rather unhealthy atmosphere in which to nurture new thoughts and create new ambitions. We must of course take into consideration the effect of these patients on the strictly medical group, and this feature will necessitate its own particular solution. However, we usually find it better to have them associated with other types, and seldom do we encounter any difficulties.

The recovery of this class of patients depends much on the confidence which we are able to establish, and that practically at the first meeting. The history, which comprises their story, is taken in considerable detail and thus one elicits certain facts that have considerable weight in the production of the conflict.

We are in most instances dealing with an intelligent group, and when a general picture of the patient's life and family difficulties is obtained, an attempt is made to have him lend his assistance to our method of treatment. Explanations within his understanding are offered, and some familiar examples given of the effect of emotional changes on the cardiovascular or gastrointestinal systems, such as blanching of the skin and rapidity of the pulse in fear, or shock; loss of appetite, in cases of worry. We would have him know that the pains he has are real and not imaginary, but that the cause is functional and not organic, and that there is marked accentuation of the discomfort because of over-attention to it. Physiologically the pain is there, and it is due to the hyperemia brought about by focusing the mind on that particular part. A widening of the blood vessels results, with increased sensitiveness, and as more blood flows by the little nerve endings, their vitality is heightened, and their sensitivity increased.

Therefore the pain is not by any means imaginary.

With this explanation, which I have borrowed from the writings of Dr. James J. Walsh, we can assure our patients that they are in no danger, and that this pain will disappear as their general health improves. Each case varies, it is true, but the essential method is one of sympathetic re-education and readjustment. We must be patient, but firm, flexible and tolerant. There are no general rules to be laid down, and we must measure the approach to each individual. The kind of sympathy we should give is rather that of encouragement, and a sense of ability to control the situation, but without being overwhelming or domineering.

Plans Must Be Flexible

A plan must be made as to rest, exercise, reading, visitors, and so forth. This, too, is individual—some need visitors for diversion, others are prostrated by them. The plan also depends much on the profundity of the exhaustion present, and the fatiguability of the patient. Baths, massage, electrotherapy, and occupational therapy are helpful, and although they are merely adjuvants in the correction of the neurosis, yet they form part of the plan and should be adhered to strictly. They should not be emphasized as specific treatments, however, merely as aids in the general re-education. It is sometimes necessary to drive a patient very hard to make him overcome certain ideas that have become deeply rooted, and much energy and patience will be required. There will be objection to going out for a walk—he is too tired; his eyes hurt and he can't read; for some reason he can't eat certain food, and can't drink milk; and many other things block constructive efforts. Remember these patients really want to get well, yet they seem to reverse the order in attaining this. But when there is absolute confidence in the physician even severe measures may be enforced.

The point I want to make is the necessity of meeting these patients frankly and honestly, without deception of any kind. Psychotherapy that is not strictly honest is bad. The use of placebos and certain electric or other treatment which carry to the patient the idea that he is getting something specific for a particular ailment that therefore must be present, in other words, treating a functional condition as though it were organic, is not good medicine and savors of quackery. I think that the neurotics are quite frequently handled in this fashion by reputable physicians, not with any malicious intent to deceive, but simply because they do not take the time to understand the basic cause of the patients'

complaints. Anything that undermines the friendly feelings of confidence and dependence on the physician will interfere with the successful management of the case. I cannot think of any instance where absolute truth is not the ideal method of dealing with psychoneurotic patients.

In closing I would sound a word of warning to hospital workers and other intensive workers, that they might beware of the insidiousness of the approach of a neurosis. It is in work such as ours where mental and physical efforts are being thrown out with a reckless disregard of our limited reserve force, that we find fertile soil for its development. Extreme fatigue, with inability to relax, loss of appetite, perhaps loss of weight, insomnia as a result of the nervous tension, various somatic complaints—all these plus our knowledge of symptoms, may make us introspective, remind us of some of the malignant conditions likely to develop, and unwittingly we are carrying the load of worry and depression. Then, too, these neuroses, are somewhat infectious, as it is frequently observed that one member of a family will influence another.

We should therefore try to understand and be tolerant of this class of patients as they come to us. Appreciating that for a long time we have been taking the human body apart and studying each organ as a separate entity, let us now put it together and view it in its entirety, with the nervous system serving as a storage battery to keep other organs functioning, and facing the possibility of burning out and necessitating frequent recharging. There is only a fine line of demarcation between the normal and abnormal and the distinction is sometimes hard to make. We are reminded of the statement that "half the world is off, and the other half not quite on," and also the comment of the Quaker to his wife, "Martha, all the world is queer but thee and me, and sometimes methinks thou art somewhat queer."

WHAT MUSIC CAN DO FOR PATIENTS

"The functions of music in hospital service are manifold. As a form of individual and mass suggestion music can be used to influence hundreds of patients. It is a physical as well as a psychical stimulant of a desirable type. It is an effective psychoanalytic agency inasmuch as it causes, through associations, old thought correlations to break through and enter consciousness with their corresponding effect, reviving not only old souvenirs but also dormant energies connected with old cherished wishes not consciously realized. In addition to analytical purposes, music may be used for synthetic aims. It satisfies a longing for esthetic experience varying in sensorial intensity from the inexpressibly tender and affectionate to overpowering forcefulness."—William Van De Wall, director, Committee for the Study of Music in Institutions.

STUDIES ON HOSPITAL PROCEDURES

THIS is an age of specialties in hospital practice. It is a time when, more and more, within hospital departments specialty divisions are being developed.

This new departure is apparently justified by the great strides that are being made in the development of newer methods in the diagnosis and treatment of disease. For example, in the medical department of our hospitals there has arisen within the past few years, a need for the more intensive study of certain conditions that hitherto have been more or less successfully treated by the general internist. Reference is made to the development of the divisions of metabolism and of cardiology. And either as a cause or as an effect of the recognition of the presence of these new fields of medical endeavor, there has been developed not only a new specialty but also new specialists—physicians who are devoting all their time and energy toward learning more concerning the diagnosis and treatment of these diseases.

It is the purpose of this article to discuss, with no attempt at exhausting the subject, some of the administrative and semi-medical phases of the hospital divisions of cardiology and metabolism.

THE DIVISION OF CARDIOLOGY

The activities of this division concern themselves with the diagnosis, treatment and prevention of heart disease. When one considers that diseases of the heart outrank any other condition as a cause of death, and that there appears in the last decade to have been a steady rise in the death rate from these conditions, the importance of the hospital and its staff directing every effort toward lowering this mortality rate needs no further comment.

It may be added here, however, that the hospital's recorded mortality rate from diseases of the heart is often rendered inaccurate by carelessness in setting down the actual cause of death. Generally, it may be said that all persons die of heart disease if they but escape for a sufficient length of time other more acute conditions, since the wear and tear of passing years work more or less certain havoc upon the cardiac muscle.

The equipment of the division of cardiology

should consist of all known physical aids to the careful study and diagnosis of diseases of the heart. It should also possess an adequate number of beds for the hospital care of cardiac cases. Not the least important part of this equipment is a well staffed and well conducted out-patient department. Discussion of this hospital division, therefore, naturally resolves itself into a description of the organization, physical arrangement and equipment of this fairly new, yet important activity in the hospital's organization.

In some hospitals where the possibilities of this specialty have been fully developed, there is assigned to the cardiologist a number of beds for the study and treatment of patients suffering from diseases of the heart muscle, its valves or its nerve supply. In these institutions the cardiologist is usually given a place on the hospital's visiting staff. It is a fine thing if such an arrangement can be made, because it brings about a continuity of supervision of, and interest in the heart patient, beginning in the out-patient department and persisting throughout his hospital stay.

Number of Beds Required

The number of beds thus set aside will, of course, depend on the size of the hospital. On account of the nature of the condition being studied, if a small ward can be devoted to this purpose, the work of the cardiologist is made more satisfactory. In the average hospital of from two to three hundred beds, if facilities for the care of a dozen patients could be thus assigned much good work could be accomplished.

Many hospitals possess an electrocardiographic or heart station, a description of which will appear below.

In new hospital construction, wires connecting the medical and heart wards with the electrocardiographic station are installed. Indeed it is usually thought advisable and efficient to connect all departments of the hospital with this laboratory, and thus to enable heart readings to be taken without disturbing these patients by transporting them from their wards to the heart station. This system is best, not only because it adds to the comfort of the patient, but also because in the case of nervous or very ill patients the readings secured may be rendered inaccurate as a result of transferring the patient from his ward or room bed to the heart laboratory.

In hospitals constructed before the study of heart disease had developed to its present stage, these wires may be placed in exposed conduits, or even insulated wires may be employed to connect the patient in his ward with the heart station, these wires being rolled on a reel similar to that

used by gardeners for transporting garden hose.

Newer developments in the manufacture of the electrocardiograph have produced a portable machine which may be easily taken to the patient's bedside. There is nothing, therefore, peculiar to the in-hospital requirements of a well developed cardiologic service.

The Electrocardiographic Station

Superintendents of hospitals are often astounded by a request from their staffs for the purchase of an electrocardiograph, costing from \$1,800 to \$3,000. It may be of interest to set down here some of the basic facts relative to the service that this equipment is capable of performing for the benefit of the patient. An endeavor will be made, as well, to answer the queries that are often asked as to whether it is really a practical addition to the hospital's equipment and whether an up-to-date hospital should expend its funds in providing such a delicate and costly apparatus.

It is a familiar picture to all of us to observe a physician, watch in hand, counting the pulse of a patient. Dr. S. Weir Mitchell states that Herman Kepler, the astronomer, was the first to count the pulse, or at least the first to record such a count before 1600. This scientist is said to have used the pulse as a measure of time. Galileo, when a medical student, used his pulse as a timepiece, when observing a large swinging lamp at Pisa and desiring to prove that this pendulum spent an equal amount of time on each side of the mid-line. Many years after, he tested his first clock by means of comparing it with the frequency of his own pulse beat. It is interesting to remember that Harvey, the discoverer of the circulation of the blood, only casually mentioned the fact that the heart beats from 1,000 to 3,000 times per half-hour.

Medicine owes much to a group of English physicians for directing attention to the physiology of the heart's action. To study clinically the rapidity and character of the heart's action, is therefore a pursuit that has made great advances in the past half century.

But while this is often the first act that the doctor performs on approaching the patient's bedside, yet he learns of the regularity and strength of contraction of but one of the four chambers of the patient's heart. The act of counting the pulse, therefore, while informative in a measure, leaves much information to be desired by the physician as to the real functioning of the patient's cardiac apparatus.

In response to a realization of this need there was developed an apparatus called the sphygmo-

graph, with which, by a combination of levers, and with the aid of a cushion or tambour placed over the patient's radial artery at the wrist, the physician was able to record in ink or on a smoked drum, a curve resulting from the contractions of one chamber of the patient's heart—the left ventricle.

And then came the polygraph, which is not infrequently used in teaching hospitals particularly, and which was a refinement over the above mentioned apparatus. This instrument records in the same graphic way the pulse wave that is felt at the wrist, as well as a wave found in the large veins of the neck. This instrument, as its name implies, therefore, produces at the same time a record of the impulses existing in the arteries, as a result of the contraction of the left ventricle, and of the wave found in the large veins of the neck caused by the contraction of the auricles of the heart. Hence, the polygraph gives the physician more information than did the sphygmograph, because it shows that the auricles of the heart contract at least one-fifth of a second before the ventricles.

But this apparatus was not completely satisfactory, because if the patient coughed or moved during this study other waves appeared which were likely to confuse the physician. Moreover it gave no more information than that these chambers did contract, and that these beats were either regular or irregular, and of greater or lesser strength.

What Electrocardiograph Records

The next step in the study of heart disease, was the development of an instrument possessing far greater possibilities, diagnostically and otherwise, than either the sphygmograph or the polygraph—the electrocardiograph. This apparatus has contributed much to the doctor's understanding relative not only to the stimuli that produce contraction of the heart but also the time relation of these pulsations of its chambers.

Now, the functioning of the electrocardiograph has nothing to do with the actual contraction of the heart, but records the nerve impulses of these contractions. While not actually comparative, one may think of the heart as representing an automobile engine with four cylinders, each one of which is connected to an electric battery by means of a wire. Every student of physiology knows that when muscles contract, impulses are caused, and while their true nature is not entirely understood, they are thought to be chemical, mechanical or electrical in their origin. At any rate, what is known as a difference of electrical potential arises, and this tiny electrical current is observed a frac-

tion of a second before the heart contracts. This current can be recorded by placing the patient's hands or feet in jars of salt solution, and connecting them by wires to the electrocardiograph.

The principle of the electrocardiograph is, therefore, of relative simplicity, consisting essentially, as it does, of a small galvanometer, such as is seen in almost any electrical laboratory. This instrument measures minute electric charges. In reality a small coil of wire is placed about a compass, and when an electric current passes through this coil, the end of the compass moves, and then falls back to its original position when this current ceases.

In the electrocardiograph in use in our hospitals, instead of the movable portion consisting of a hand such as is seen on an ordinary compass, it consists of a very fine quartz thread called the "string." This "string" is suspended in a magnetic field, and when a minute current passes the thread, it is bent to one side moving only a fractional part of a millimeter (.0393/7 of an inch). Of course such a small movement must be greatly magnified to be recorded, and this is done by the use of a microscopic lens. The shadow of this movement is then photographed upon a sensitive film, such as is familiar to many hospital superintendents, and the result is a continuous curve, which graphically represents the electric impulses incident to heart contractions.

The above brief description of the principle of the electrocardiograph may serve to make the delicacy, and therefore the cost of this instrument, more understandable.

Location of Heart Station

Serious thought should be given by the superintendent and the cardiologist to the proper location of the heart station. An instrument as delicate as is this one, which is dependent also for the accuracy of its recording upon the absence of jars such as would be transmitted to the machine by unstable floors, or by the starting and stopping of elevator machinery nearby, should preferably be placed on a ground floor, of cement or other similar construction. It would appear, however, that the belief that special concrete foundations must be constructed upon which to place this apparatus, is not always justified. Indeed, in some hospitals, the electrocardiographic station is located a number of floors from the ground, and no special attempt has been made to strengthen or stabilize the floor of the room in which this instrument is being used.

In constructing this suite it is necessary to provide a dark room for the development of the electrocardiographic films, and it is preferable to

have one or more cubicles into which the beds of the patients can be wheeled, if it is necessary to bring them to the heart station proper.

With the development of ward wiring, as has been intimated above, it is not necessary even to move the patient's bed. The avoidance of excitement, incident to the conduct of an electrocardiographic study is always advisable, no matter how far distant the electrocardiographic station is from the ward. The arrangement now in common use in hospitals is to place outlets in wards and rooms for plugging in, not only for the recording of electrocardiographic studies but also for telephonic connections with the heart station, so that the operator in the ward can inform the technician in the heart station when he is ready to proceed with the tracing. In many new hospitals, it has been thought advisable not only to connect various hospital departments with the electrocardiographic station, but also to place outlets in the operating clinic, and even in some dispensary rooms.

How the Division Functions

When a visiting physician desires to have an electrocardiographic study made of a patient in his service, a request form is sent to the heart station. Upon this form is usually set down, besides the patient's name and age, his clinical diagnosis and a brief abstract of his history. In addition, information is furnished as to treatment that has been given, and particularly is a note made of the amount of digitalis that has been prescribed for the patient. If the ward is wired, as has been described above, the technician from the electrocardiographic station comes to the ward, applies the electrodes to the patient's arms or legs and phones the heart station when he is ready to begin his record. After the electrocardiographic film has been developed, the cardiologist fills out the report sheet, which is usually of the same size as the history blank being used, and returns these findings to the ward physician.

It has been said that almost any person of average intelligence can learn, within a comparatively brief time, to record electrocardiograph tracings, but that, as is the case with x-ray plates, much skill is required to interpret these findings properly.

It has been intimated above that the expense of the installation of this equipment is considerable, and the question is oftentimes asked by hospital superintendents whether their institutions can be considered modern if they do not possess an electrocardiograph. It can certainly be said in reply to this query, that the electrocardiograph has passed beyond the stage of experimentation, and

has taken its place as a real addition to the equipment necessary for the scientific study and treatment of disease. It is believed by many that no hospital which purports to be modern in every respect should be without this apparatus, and that the specialty of cardiology has come to stay and can contribute much that will benefit those afflicted with disease of the cardiovascular system.

The Heart Clinic

As can be said of almost any other condition treated in the hospital, there must be, in addition to in-patient facilities, an out-patient cardiologic department. Some institutions maintain this clinic as an adjunct to the medical dispensary. Others conduct it as a separate clinic, which meets at a time other than the general medical out-patient clinic.

The cardiologist is usually chief of this clinic, and the interns and nurses assigned to his service complete its personnel. There is no more inexcusable waste of hospital effort than that which is represented by carefully nursing the cardiac patient back to comparative health, and then neglecting to supervise his activities after he leaves the hospital. It is in the cardiac clinic that many of the sound preventive medicine activities of the hospital should manifest themselves. The social worker, upon the advice of the physician in charge, endeavors to adjust the patient's employment to his cardiac strength and to supervise his home life, to prevent recurrence of the cardiac embarrassment that caused his original hospitalization.

Ofttimes patients who have experienced restored function after hospital treatment, do not realize the necessity of returning regularly to this clinic. The social worker must then visit the patient's home, or employ the mails, to impress upon the patient that it is greatly to his interest to return to the clinic. It is this worker who transmits to the patient information concerning such danger signs as swelling of the ankles, shortness of breath, blueness of the lips, or the expectoration of blood—symptoms that indicate the advisability of an immediate return to the hospital on the part of the patient.

Here the most detailed records should be kept. The chart that has been devised by the heart committee of the New York Tuberculosis and Health Association, New York, is in use in many hospital heart clinics in its original or modified form, and represents a most careful study of the medical and social life of the patient.

A close liaison between the heart clinic and other clinics in the hospital is, of course, most necessary. These patients may require the atten-

tion of the hospital dentist, to remedy infected mouth conditions; of the laryngologist, to remove diseased tonsils; of the genito-urinary surgeon, to inquire into the possibility of other infective foci, which may account for heart damage.

Nor should the heart clinic deal only with patients who have suffered irremediable cardiac damage. To it should come children of school and pre-school age for examination and supervision, in order that conditions that are known to be causative of heart disease may be prevented before they occur.

From this clinic should also emanate public health information as to the fact that that triumvirate of conditions—rheumatism, tonsillitis and chorea (St. Vitus dance), while not in themselves serious, are dangerous, because they so often are productive of damage to the heart.

Finally, it may be said that there should be a coordination of in-patient and out-patient effort which has as its aim the prevention of the original heart damage, the restoration, in so far as possible, of those requiring bed treatment and the prevention of relapse, resulting from inappropriate occupation in those cases that have been required to seek the hospital's aid and have returned to their work.

Over two centuries ago, René Laennec, a French physician, announced that one could learn much concerning the sounds of the heart by placing some solid body between the ear of the examiner and the chest of the patient. Thus came into existence the stethoscope, which today is such an aid to the physician in clinically studying the diseases of the cardiac apparatus. 'Tis a far cry from the crude instruments of Laennec to the modern stethoscope. But the variance between the pocket stethoscope in general use by physicians of today, and the electric stethoscope possessed by some medical schools and teaching hospitals, is almost as great. By means of electric magnification and transmission, this instrument can detect not only hitherto undreamed of gradations of intensity in sounds produced in the chest, but the heart sounds can be so magnified as literally to fill a large classroom. The cost of this instrument is not inconsiderable (approximately \$2,500), but its advantages from the teaching standpoint are thought to justify its purchase.

THE METABOLIC DIVISION

The discovery of the process that enabled Dr. F. G. Banting, Toronto, and his co-laborers to isolate from the pancreas of animals the substance that they named "insulin," has given a great impetus to the study and treatment of diabetes. It

is a mistake, however, to consider that the hospital's metabolic division should only be concerned with the treatment of this disease. Metabolism is a term that concerns itself with the bodily processes that are carried out in the absorption and translation into actual body cells of the end products of digestion.

Now, in many diseases there is a derangement of body metabolism, and therefore such conditions as high blood pressure, gout, certain types of goiter and many other conditions can be appropriately assigned to this division.

Purpose Served by Division

As to the need for the existence of a metabolic division, it can be said as it has been said of the division of cardiology, that patients suffering with metabolic diseases may be more intensively studied and treated in a room or ward that has been especially equipped for handling these conditions. It is a well known fact that in the diabetic the desire for carbohydrates (sweets, starchy foods and vegetables) is of such an impelling nature that patients find difficulty in controlling their appetites for these substances.

In one hospital a diabetic patient, who was being treated in a general medical ward, was observed to arise stealthily from his bed and crawl under half a dozen other beds and remove some candy from the table of a patient at a considerable distance from his own. Friends and relatives, not understanding the harm that may be done a diabetic patient by the consumption of carbohydrates, oftentimes yield to their pleadings and bring them this forbidden food. It can be truthfully stated, therefore, that no diabetic patient, for example, can be as successfully treated in a general medical ward as in such a special ward.

Physical Equipment Needed

The physical equipment necessary for the proper conduct of a metabolic service consists of ward or private room provisions to house the number of patients of this type found in the particular hospital's clientele. If ward service is to be offered, these units should not be of more than four-bed or six-bed size. Then, too, the study of the chemistry of the human body requires equipment that is usually not available in the ordinary medical suite.

Because of the fact that a gangrenous condition of the extremities is often associated with diabetes, it is usually found necessary to have small isolation rooms for the treatment of these patients. No less necessary is the presence of special isolation rooms for the care of patients who are admitted in coma. Unconsciousness is,

as many know, a manifestation of an extremely toxic state, sometimes seen in untreated diabetics.

Reference has been made to the need for appropriate laboratory facilities. In the use of insulin, frequent estimations of the concentration of sugar in the patient's blood and urine are of the greatest importance. In slightly less degree is it necessary for the physician to be informed concerning the presence of a pre-acid state in the patient's body, and facilities for the chemical study of the patient's expired air are important additions to this suite.

It may be said, therefore, that decentralization of the hospital laboratory, in so far as the presence of facilities for the carrying out of the above suggested chemical studies, appears indicated, and that the metabolic suite should have a complete laboratory adjacent thereto. Of no less importance is the need for an efficient diet laboratory in this division. Here must be prepared many of the articles of food employed in the treatment of diabetes, and the supervision of the visiting physician of this division over the diet laboratory must be most intimate and his authority here complete.

Functioning of Metabolic Division

The metabolic physician is in full charge of this division, including its laboratory, diet kitchen and out-patient department. All patients admitted to the hospital suffering with any of the diseases to be treated here, are usually sent direct to this division rather than to the general medical wards, and later transferred therefrom. If this system is not in vogue, all such patients are admitted to the general medical wards and then are transferred to the metabolic division. The former of these two systems appears to be the most efficient.

Oftentimes a physician in the general medical wards desires the opinion of the metabolic physician in regard to the diagnosis or treatment of one of his patients. A consultation form is sent to the metabolist, and if at the time of consultation he believes that the patient should be transferred to his division, this agreement is reached then. Upon the conclusion of this study, the patient is retransferred to his original service.

The records of the metabolic division must be most accurately kept. A form for recording food intake as well as the results of laboratory studies should be used for this purpose.

Most metabolic divisions have carefully worked out history forms for the recording of symptoms, blood pressure estimations and so forth.

This division can also render valuable service to other departments by calculating dietetic requirements for patients sent there for study.

Since diabetes is a condition that may exist over a long period of time, it is obviously impossible for these patients to be maintained in a hospital ward until they no longer need the physician's attention. This brings about a situation that requires careful instruction of the patient in regard to his own diet, and even in regard to the self-administration of insulin. It is remarkable how quickly ignorant patients learn basic dietary facts, even becoming adept in the aseptic use of the insulin syringe.

Lengthy Supervision Necessary

Many of these patients must be supervised over long periods of time—hence the out-patient clinic. This clinic is oftentimes located near the metabolic diet kitchen, so that actual cooking demonstrations can be given there. Frequently one finds in well organized departments, regular classrooms equipped with blackboards and charts, in which detailed instruction may be given by the metabolic dietitian, the metabolist or his assistant, concerning the personal hygiene of the patient after leaving the hospital.

The metabolic clinic, since the estimation of blood sugar must be taken at the longest possible time after food consumption, is usually held rather early in the morning. At this time the physician in attendance secures blood samples, and after reading the results of these chemical examinations, he is able to regulate the insulin dosage and to give advice relative to the patient's diet. Dietary cards and other information which the patient should possess, are issued from this clinic. If the chemical studies denote that the patient is not observing the instructions that have been given him, a social worker is then sent to his home to learn, if possible, what deviation from the prescribed diet has been made. The hospital stay, therefore, in uncomplicated cases may be of but comparatively short duration.

During this time, a study of the patient's body chemistry may be made and a diet may be worked out that will permit him to go about his business, returning to the hospital clinic for supervision only.

In this way a comparatively few hospital beds may serve a large number of patients.

TRAINED LABORATORY WORKERS ARE ESSENTIAL

In a paper on "Equipping a Small Hospital Laboratory" by Dr. H. W. Hill, director, Vancouver General Hospital Laboratories, Vancouver, B. C., and Dr. R. E. Coleman, assistant director, Vancouver General Hospital Laboratories, occur the following interesting comments on the need for trained workers in the laboratory: "Having decided first on the demands your hospital must meet,

and then on how far you can go financially in equipment, remember that the crucial point is after all the trained, skilled, conscientious worker, with time that can be given to making the examinations correctly and well. Without this efficient worker, the kingpin of the whole plan, no equipment, space, or financial freedom will achieve the hoped-for result—a reliable laboratory service.

"If a trained worker is available ready to hand, get that trained worker first, part time if necessary—a practicing physician or a nurse, perhaps. By all means let him or her equip up to the limit of your financial ability in laboratory expenditures. But if there be no one immediately available, then you must train someone, or let him or her be trained for you in some larger hospital laboratory. Select from your staff someone, say a nurse, willing to be trained. The more complete the training, the better ultimately the laboratory.

"If you must begin in a small way, with only the first unit—urines—then have your prospective worker trained thoroughly in that one item. The university will be glad to arrange with any small hospital in British Columbia for the preliminary training of a nurse in these lines; the Vancouver General Hospital Laboratories will be glad to supply the final experience and polish. From two to three weeks should be sufficient to train a nurse, and the only cost would be for materials expended, perhaps \$2 to \$5. Bit by bit, thereafter and in your own laboratory she may be trained or may indeed train herself in the other items, adding them to your service as your facilities, financial and otherwise, increase. If you wish, the university and the Vancouver General Hospital will arrange for this more advanced training also, in blood work, sputums and other items.

"Let us emphasize again that your worker, whoever he or she may be, will inevitably prove to be the central pivot of your laboratory—that point on which all else rests, and that point which will determine its ultimate success or failure. We stress this because the worker hitherto has been taken too much for granted in the literature available to us on small laboratories. Equipment has been stressed. It is important. Without equipment no one can do anything. But, granted equipment, it is 'the man behind the gun' after all."

WHY A DEFINITE EDUCATIONAL PROGRAM IS NEEDED IN MENTAL HOSPITALS

Increasing need for a definite educational program in mental hospitals is brought out in a recent address by Willem Van De Wall, field representative, Bureau of Mental Health, Department of Welfare, Pennsylvania, who says in part:

"Admissions to the mental hospitals of later years show a lowering of age minimum. Children of school age are seen in increasing numbers on the wards. To whatsoever specialization this may lead in the future, for the present these cases have to be treated and cared for by the same institutional systems that care for older patients.

"The presence of these juveniles asks not only for a re-educational system but for a straight educational department in the mental hospitals. These establishments will become more and more research laboratories and training schools for the art of living and centers of mental hygiene pedagogics. The fundamental principle of this teaching or mental rearing will be the leading out of the individuality to its greatest development and self-fulfillment in socialized forms.

Editorials

A MENACE TO THE NEWBORN

IT IS a fact significant of the continuous alertness of doctors and nurses that so few cases of poisoning from accidental administration of drugs occur in our hospitals. But now and then we are shocked by the seemingly avoidable loss of life incident to the ingestion of one of the drugs useful in the treatment of disease.

Borax and boric acid are in daily use in most of the hospital's departments. Indeed familiarity with this drug may have bred contempt for its potential dangers.

In the maternity and pediatric wards particularly, boric acid solution of from 1 to 3 per cent concentration is often employed as a mouth or eye wash, and for the cleansing of nipples and bottles.

Boric acid has no active germicidal power and is more useful as a preservative than as a disinfectant, because it checks the growth of putrefactive organisms. Nevertheless it is commonly employed in treating certain infectious mouth conditions in infants, and this and other undisputed uses will probably make it a drug commonly found in the drug closets of the pediatric and maternity services of the hospital.

Preparations of the strength usually employed are but mildly toxic, and even in saturated solutions—except when employed in the irrigation of large cavities, such as the pleural sac or the colon—are usually not harmful. On the other hand, a solution of this drug has been administered to infants in mistake for sterile or barley water, and has not only produced serious poisoning, but in a recently reported instance death has resulted from its ingestion.

How can the hospital prevent these calamitous occurrences? By impressing upon nurses and attendants that borax and its solutions are dangerous drugs if improperly employed. By clearly labeling bottles or flasks containing its solutions; or, in addition, by placing a few drops of some harmless dye, such as methylene blue or carmine, to make visual differentiation from sterile water or salt solution more certain. By employing some other solution, such as sterile sodium citrate or even normal salt solution, as a medium for cleansing bottles and nipples. By remembering that the chief symptoms of poisoning are vomiting, scanty urine, skin eruptions, somewhat like that of scarlet fever, fall of temperature and collapse, and

that the appearance of any of these signs in a baby or an adult, who may have ingested boric acid, calls for immediate medical aid, if life is not to be endangered.

Perhaps the best of all these remedies is the elimination of the use of boric acid in the maternity wards, and the use of a substitute of equal potency and of less toxicity.

A SIGNIFICANT ACHIEVEMENT

OVER a period of years the editors of THE MODERN HOSPITAL have been watching the development of a notable health and hospital program that has quietly been unfolding itself on the western edge of the continent.

Fragments have from time to time been published in THE MODERN HOSPITAL regarding this health organization which has come to be known as the Alameda County Hospital Plan. It has been considered desirable, however, to await the completion of the general hospital for acute medical and surgical cases before offering to the hospital field a picture of the whole interlocking scheme of health and hospital service. Such an outline sketch is now presented, and to those who will thoughtfully consider the significance of the program in its entirety, and the features that distinguish it from similar services in other communities, no explanation is necessary for the amount of space devoted to the subject in this issue.

The Alameda County Hospital Plan has been developing over a period of approximately nine years. It is no longer in an experimental stage but has been in operation long enough to permit of conclusions regarding its value. The relation of public health and hygiene to the general economic circumstances of the community are obviously of the greatest interest and importance, and the system that has been worked out in this instance should place Alameda County in the first rank in the country in regard to the provision made for the care of its dependent poor in time of sickness. It may well prove a mental and moral stimulus to other counties who are facing similar problems. There are many physical plants on the continent that perhaps have a higher degree of development than has the Alameda County group, with the notable exception of Highland Hospital. However, it is not the physical plant that impresses one but rather the spirit of service and the philosophy of operation in this rather Utopian scheme of care for the indigent sick.

Statistics show only inadequately the real work

that has been done. Much of the most valuable work that has been accomplished cannot be so conveniently labeled and counted. The economic phase is self-evident, but if there can be written into the operation of our governmental hospitals a great love of mankind, surrounding the operation with a broader conception of the health of a community, as has been done in Alameda County, then a great service will have been accomplished for the American people.

"KISSING THE PLACE TO MAKE IT WELL"

TRAINING nurses to be more intelligent as well as more efficient and teaching them to be courteous and well mannered is a practice that is being introduced into some of the eastern hospitals of the country. It is an idea worthy of the deep consideration of every hospital superintendent. Too much attention cannot be given to nurse training and particularly does this hold true in teaching the student how to act, as well as what to do at the bedside of the patient no matter what the social or financial status of that patient may be.

The patient enters the hospital in a peculiar state of mind. He is not his usual self, and is probably more irritable than is his wont. He is easily ruffled, he speaks before he thinks. But he is as impressionable as ever and a brusque nurse, no matter how competent, disturbs him. He resents the too businesslike and cold demeanor on the part of her who should make his stay comfortable and should help him to get well. He is a little boy again seeking sympathy for his bruises and the friendly interest on the part of the nurse is the equivalent of "kissing the place to make it well." It is human understanding and kindly sympathy, not cold cures and efficient bandaging, that the patient craves, although it is perfectly possible to give him both.

In the big general hospitals of the country the main contact that the patient has with the management of the institution is through the student nurses. If they are indifferent or if they are simply automatons performing their duties without an ounce of psychology, the patient will leave the hospital vowing that it is a pretty poor place, no matter how efficiently he has been treated. While it is not our object to advocate veneer, nevertheless a nurse who understands a little patient-psychology will do more to create a good impression and to make a friend and booster for the hospital than that thoroughly efficient person who always does things rightly but never cheerfully.

ARE YOU PROMOTING VACCINATION?

IN WRITING case histories, does the staff of your hospital insist that careful note shall be made as to whether or not the patient has been successfully vaccinated within three years? If the patient has not been vaccinated, is he followed up and an attempt made to have him vaccinated?

At the present time, the United States has more small-pox than any other civilized nation. Ignorance, carelessness, indifference and the "isms" are largely responsible for this. To be sure, most of the small-pox now is of the mild type but every now and then there is a case of the hemorrhage type, with the result that death frequently occurs within forty-eight hours.

Most vaccinated persons never contract the disease but should they, it is almost always in a mild form. The word vaccinated, here used, means properly vaccinated. Not all vaccinations are carefully done, but if hospitals will undertake to increase the number of vaccinations in their community, they can ensure to their clientele careful vaccination and by so doing will afford a great measure of protection. The hospital and the community will thus save themselves much trouble and expense and will be doing a genuinely useful piece of public health work.

PRECEPT OR PRACTICE

HOSPITALS must have rules. These regulations usually originate in the superintendent's office, although at times they are simply transmitted by the superintendent from the board of trustees.

But exception to their observance should not be expected by any member of the resident or visiting personnel, high or low. Class legislation is particularly obnoxious to the American citizen. To forbid the orderly to smoke in the corridors of the hospital and to wink at this practice when the fire is at the end of the chief of staff's cigarette, is neither consistent nor courageous.

It is a curious fact that some hospital administrators, who require of others the strictest observance of their mandates, are prone to break their own rules with the greatest of ease. Such a superintendent was recently making rounds with a visiting colleague. When he unduly delayed closing a screen door, leading to an operating room, he was politely yet positively asked by the nurse in charge whether he would not step inside, and thus prevent the entrance of flies. Such an act on the part of the nurse required not a little bravery, but it was wholly justifiable and brought,

as it should, commendation from her superior.

There should be no rigid observance of the rules of the superintendent than that by the originator of these edicts. "Do as I say, not as I do," is an expression that is not consistent with the enforcement of any law, whether it be of a nation, a state, a city or a hospital.

TALKING IT OVER

SOME hospital executives who read the comments on postmortem percentages contained in the recent report of the council on medical education and hospitals of the American Medical Association, were no doubt shocked to realize that their own institutions were not considered satisfactory from this standpoint. Four hundred and fifty-three out of 578 teaching hospitals performed postmortem examinations on less than 30 per cent of the patients dying in these institutions in 1926. Nor does it seem unreasonable for this body to announce that after January 1, 1928, approved hospitals must possess, at least, a 10 per cent, and after January 1, 1929, a 15 per cent postmortem percentage. This is certainly a matter that deserves the serious consideration and encouragement of all men and women directing the hospitals of this country.

THE old idea that resulted in "crippling" patients by an excess of gratuity and the indiscriminate giving of free service is rapidly passing, and the cause of patients paying in some small measure for their hospital care is now being championed by more and more lay people. Also, that donors are beginning to recognize that it is just as charitable to help patients to pay their hospital bills as it is to pay those bills for them is well illustrated in the recent \$100,000 contribution to a southern hospital by a local merchant, who specified that the sum should be used for a part-pay ward.

THERE is waste and waste. The varieties of this commodity considered in Dr. Doane's article on page 80 are of the more subtle type that is hard to detect and hard to check. Supplies can be labeled and counted; not so time and opportunity. These cannot be so conveniently measured. Yet how infinitely greater is their value; how much greater their loss, in the last analysis, than the loss of supplies or equipment, which, after all, can more easily be replaced. There is but one psychological moment to grasp time or opportunity—it is the present day, the present hour, the present moment. Let us not waste these. Much of the waste that is occasioned by inefficient methods of administration could, Dr. Doane feels, be eliminated and a higher plane of efficiency reached by better coordination of departments and the establishment of more definite schedules of work.

IS THE circus coming to your town soon? When it does, I go to the show grounds and suggest to its manager that you know some boys and girls who are ill, and who range in age from two years to three-score-and-ten, who would be made happy if a show could be given at the nearby hospital. You will be surprised how interested this man of the sawdust trail will be in your request, and how

promptly he fixes the date for the exhibition. Circus people have hearts as large, figuratively, as their elephant is literally, and nothing delights them more than to make others, less fortunate than themselves, happy. Besides, it pays to advertise, and a hospital exhibition contains some of the best elements of good publicity.

SOME hospital people, as a distinguished humorist has put it, are of seventy-horsepower, full of gas, but making only five miles to the gallon. The spark of initiative is strong; the physical ability and the mental will to do are present, but mileage is expensive and progress is slow, because the carburetor of coordination fails to combine these elements into a mixture that produces satisfactory results.

IT IS stated that Gaelic has no present tenses for its verbs and that the language must therefore concern itself with the past and the future. Aren't there a lot of people whose minds follow this trend, always thinking of what has gone before and what lies ahead, leaving out of consideration what is happening today? Every present day is the best day that ever was. Today we are alive; yesterday is dead; tomorrow we may be also. Yesterday was a lesson; tomorrow may not come for us; today is vibrantly alive, brimming with problems and opportunities. Yesterday may be a regret; tomorrow may be a disillusionment; today is a reality. Days that are past and days that are to come are Never-Never Land; the present is the only tangible yardstick of Time.

THE following are translations of a few of the maxims contained in Crouzel's *Aphorisms Vécus*. They have a bearing on the hospital field:

He who thinks each day of the future is never caught destitute.

To succeed in life, one should have a single aim, never lose sight of it and concentrate every effort upon it.

Friendliness is rarely disinterested.

Spite begets hate.

It is better to pass for a grouch than for an imbecile or a hypocrite.

Frequently one thinks only when the irreparable has occurred.

SOME alliterative genius has evolved the maxim, "Pep without purpose is piffle." In America we place an undue premium on "pep" which, in the great majority of cases, is nothing but a busy delirium. It isn't the horse that prances the most that does the most work and arrives at its destination in the best condition. A good many "peppy" horses lather themselves all up to no particular purpose. A good many people are very much the same way. Noise, bustle and hurry are the breath of life to their nostrils and they make as much fuss over accomplishing a small piece of work as a more efficient person would over a life's accomplishment. Pasteur was not a "peppy" man, yet he revolutionized the world's thought with regard to disease. Lister could not have qualified as a man of "pep," yet he raised surgery from a craft to a science. Lincoln did not have to hustle and bustle to make himself one of the great men of all time. It is quiet, steady continuity of work and intelligence that accomplishes things. It is the man with purpose who makes the world better for his having lived. Truly, "Pep without purpose is piffle."

The Modern Hospital Reading Course: Lesson VI

PRINCIPLES TO BE APPLIED IN HOSPITAL ADMINISTRATION

By E. H. Lewinski-Corwin, Ph. D., Director, and A. E. Conover, M. D., Assistant Director, Hospital Information and Service Bureau of the United Hospital Fund of New York.

PROPER organization is the *sine qua non* of efficient performance. It is, however, sometimes made too much of a fetish. The human element, without which no organization, no matter how perfect, can function properly, should never be left out of account. An organization is good when it creates a working environment conducive to the best quality of performance without sacrificing the potential capabilities of anyone within its confines, and when it stimulates everyone to do his duty cheerfully and without stint, as well as without jeopardy to his health or to the health of others with whom he comes in contact.

Organization in industry and business has become an object of intensive study by engineers and economists. Since the days of the late F. W. Taylor a new science has come into existence, that of industrial and business management. It received considerable impetus during and since the war. Job analyses, unit cost accounting methods, the application of psychological principles in personnel management, industrial hygiene and welfare work, wage determination on the basis of productivity, are some of the plinths on which the new structure has been reared.

Good administration consists in the successful application of certain principles of common sense and fairness. It calls for organization, capacity for leadership and devotion to duty.

The generally recognized first principle of administration is a clear-cut statement of policy. As Webster Robinson in his book on "Fundamentals of Business Organization"¹ points out, policies must not be understood as rules of action, but rather as outlines of a course of action.

A superintendent of a hospital can hardly discharge his responsibility to his own entire satisfaction or that of others, if the trustees of the institution have not clearly defined the policy of the hospital with regard to the scope of its work, its

responsibilities to the community, to the poor, to the middle class patients, to the medical profession, to research and teaching, and if they have not formulated the course they desire to take in the many other relationships that the hospital must maintain in its productive and consumptive capacities. He will take one course of action if the hospital is to be self-supporting from its earnings, and another if it is to have a broad charity aspect. He will deal differently with the demands

of the medical staff, if the hospital is to engage in research and teaching, than he would if the work were to be carried on in a certain routine manner. Whatever be the policy of the hospital, it must be definite and not liable to change from day to day. There can be no efficient administration without the guiding chart of a definitely formulated policy.

By the nature of its work, the hospital must be organized on a functional basis, although in each major department the line or line-and-staff type of organization may be introduced, depending on the character of work and the personality of the division chief. The nursing department and some administrative functions are best organized according to the direct line or "military" method; other departments, particularly the medical, are functionalized and have the line-and-staff form of organization.

The business of management is to coordinate, to harmonize and to synchronize all the functional units in the organization, to provide centralized executive direction and control. It takes natural executive ability, a trained, analytic mind and a sympathetic personality to make a successful manager. In his excellent syllabus of "Industrial Organization and Management,"² Professor William B. Cornell emphasizes the fact that there are no

Suggestions for Reading

"Business Administration," by Leon Carroll Marshall, University of Chicago Press, Chicago.

"Fundamentals of Business Organization," by Webster Robinson, McGraw-Hill Book Company, New York.

"Industrial Organization and Management," by Professor William B. Cornell, New York University Press, New York.

"Hospital Organization and Operation," by Frank E. Chapman; Chapter I., The Macmillan Company, New York.

¹ Published by the McGraw-Hill Book Company, New York, 1925.
² New York University Press, New York, 1925.

set rules to insure executive success. He stresses, however, certain personality traits and methods of conduct. To quote Professor Cornell:

"The quality of leadership must be inherent, but it must not be allowed to lie dormant, or to run rampant. It must be properly utilized and developed. The executive must be a believer in teamwork and must continually practice it, at all times conscientiously working with his fellow executives to promote and carry out the policies of the concern.

"Self-control is prerequisite to success in business. To be an executive—a manager of men—one must first manage oneself. The calm executive inspires like conduct in others. Calmness, as well as emotion, is contagious. A mild but firm executive is reliable. He can be depended upon to face all issues openly and fairly. This reassures the employees and promotes good feeling and co-operation.

"Last, but far from being least in importance, the executive must have a trained mind—must be a seeker of facts—one who analyzes his problems rather than jumps at conclusions."

Flexibility of Cardinal Importance

No organization should be allowed to become inhuman and inelastic. This particularly applies to hospitals and to scientific institutions. To treat disease or to do scientific work is different from manufacturing steel or collar buttons. Method and organization are essential, as well as the practice of economy, but never at the expense of real, creative efficiency, kindness or loyalty. It is good policy to buy standard articles, but it may be a good investment to depart from this policy to satisfy certain peculiar conditions; it may be good practice to have a central filing system for records, but if by reasons of distance or inaccessibility it should interfere with the ready use of it for scientific reference, good judgment dictates a decentralized filing system.

Examples of this type could be multiplied. Suffice it to say that stupid insistence on form without regard to substance and to convenience of personnel is bad management. This is not to be understood, however, as disparagement of rules and the enforcement of them. It is merely meant to emphasize the importance of the exercise of true wisdom and sound judgment in the formulation of rules. Rules are indispensable in any kind of organization, and should be formulated with precision, in clear easily understood language, and should be printed or multigraphed in a manual to be given to every employee, for his information and guidance. The function of every officer and employee should be definitely stated as well as

his rights and duties. This fixes responsibility and helps to diminish duplication of effort and the causes of friction and of discontent. It helps to maintain discipline and the morale of the organization.

The rules and regulations should be worked out by the superintendent in joint conference with the department heads and then submitted to the trustees for their approval. Every hospital job should be classified and the duties and responsibilities of each explicitly stated in sufficient detail to make them intelligible to every employee from the highest to the lowest. It is to be expected that from time to time changes will have to be made, experience will call for modifications and new rules will have to be made to replace old ones. One of the most valuable pieces of work accomplished by staff conferences is to reveal the need for such changes and to make constructive suggestions for modifications and additions. Employees who actively participate in constructive work of this kind develop a new attitude towards hospital rules and regulations.

In addition the head of each department should carefully prepare a job schedule or a schedule of work for each employee with the approval of the superintendent. This relatively simple procedure would save much sorrow and vexation of spirit for all concerned and do away with the endless haranguing as to whether it is "my job—or her job—or his job" which usually ends up by its being nobody's job. Most amazing results have followed in many institutions where this job schedule has been introduced.

Definite Schedules of Work Needed

Another valuable feature of the procedure is that each worker can anticipate his next piece of work and prepare for it. Nothing is so demoralizing to workers as not to know one minute what they will be doing the next. Usually it produces mental confusion and a feeling that they are being imposed upon and having something put over on them.

Included in the rules and regulations should be a clear and definite statement as to who is the "boss" of each worker, and he should not be expected to take orders from any person other than the one designated. Everyone has seen first rate workers become surly and resentful for no other reason than that they were being "bossed around by everybody." The hospital administrator will do well to remember the old Bible adage that "no man can serve two masters, either he will love the one and hate the other"—in modern times the employee often ends by hating both.

The administrator of a hospital has many and

varied duties. His position is fully on a par with an administrative officer of an industrial enterprise, except that he is not directly responsible for the performance of the medical staff. His position is likewise different from that of a manager of a factory or railroad in that he is hampered by a lack of adequate personnel, a handicap that cripples the proper functioning of any organization. He is often called upon to fill the role of general manager, comptroller, accountant, statistician, purchasing agent, supervisor or inspector.

Show Confidence in Superintendent

The hospital superintendent further suffers at times from the interference on the part of the president or individual trustees in the discharge of his duties. No member of the board of directors of a business concern would think of making casual visits to the factory of the company or of issuing orders to foremen or other employees. No manager would tolerate such dictation. Such a meddler would be suspected of insanity. Hospital management is, however, regarded for some reason as being outside the pale of business custom and ethics, and is a happy hunting ground for interference. Unless the hospital superintendent enjoys the confidence of his board of trustees in the same measure as does the business executive that of his board of directors, a cardinal principle of hospital administration has been obliterated.

must be laid down by the board of trustees, but the working out of ways and means to execute these policies, and the details involved must be left entirely to him. He should account for all his acts to the board and to such committees of the board as it may be desirable to create for the control of the work and for the financing of the hospital.

Physician Undesirable on Board

No physician should be a member of a board of trustees of a hospital. At first blush this may seem a radical principle. It can, however, be amply defended. It is self-evident that when a physician is on a board of trustees of a hospital and is on active service at the same hospital, he exercises undue influence in comparison with his colleagues who do not occupy such a dual position. Should he have no professional association with the hospital in which he serves as trustee, he is nevertheless regarded by the lay members of the board as particularly conversant with hospital affairs and undue consideration is given to his judgment. In this way a super-medical opinion is being established. The most important consideration, however, is the fact that much of the business of the board of trustees is of financial and economic character, and the physician is not by training and instinct fitted for the performance of this function.

Department heads should be appointed and dis-

Review Work

1. Devise a complete job schedule for the housekeeping department of some hospital well known to you.
2. Draw an ideal organization chart for a private hospital of 150 beds, showing relations between superintendent, heads of subdepartments, board of trustees, committees of the board of trustees, women's auxiliary, visiting committee of women's auxiliary, social worker whose salary is paid by the women's auxiliary.
3. Outline the order of business of a board of trustees.
4. Outline procedures to be followed in conducting a superintendent's conference with department heads of his hospital.
5. Draw a chart showing relation of board of trustees, superintendent, resident medical staff, and attending medical staff.
6. Suggest ways and means of reducing labor turnover.
7. Make an ideal house order to be issued by the superintendent of some hospital known to you concerning the regulation of vacations, sick leave and leave of absence.
8. Prepare head lines and a brief outline of the articles to make up a monthly publication for general publicity purposes for some hospital known to you.

An incompetent superintendent should be removed from office, a capable man should not be interfered with in his field of work. The board of trustees that wisely endows the superintendent with full power and authority to administer the affairs of the hospital has laid the corner stone upon which the entire organization depends. To be sure, policies and principles for his guidance

missed by the superintendent. It should be a maxim of hospital administration that the person in whom is vested the power to appoint, is also vested with the power to dismiss.

In the case of departmental employees, the superintendent should delegate this power to the head of the department, but in cases where the dismissal reflects upon the character of the indivi-

dual, a full report of the matter should be given to the superintendent. Appointive and dismissal powers over student nurses should be lodged with the head of the training school, and, over the resident medical staff, with the superintendent, who may ask the advice of the committee on interns of the medical board. The vital importance of giving department heads this authority can hardly be overestimated, as a soldier in battle without firearms is no more helpless than a department head without the power to "fire."

Whenever two or more persons work together under one roof differences arise and adjustments and compromises must be made. Almost two-thirds of the population under the hospital roof is made up of employees and one can safely say that two-thirds of the administrative problems are to keep this human machinery running smoothly and effectively. In the judgment of those who have tried it, the weekly staff conference is the most effective lubricating oil that has been found so far. Here grievances and misunderstandings can be brought forward and ironed out—there is nothing like a public recital of a grievance to show it in its true proportions.

How to Avoid Misunderstandings

But these conferences should be preventive in their character as well as curative, and there is no better way to avoid misunderstandings than to bring about a full comprehension of the other fellow's job and his tribulations. For this purpose the first part of each meeting should be devoted to a presentation of the problems of some particular department by the head of that department, for instance the laundry or the kitchen.

This should be followed by a general discussion on the subject, with suggestions by members of other departments, especially those that have a close working relationship with the one under consideration. Petty differences of department heads seldom need to come up at the conference. It is also unwise to take up in these conferences matters that concern but one department and the superintendent. The superintendent should take great care never to embarrass a department head by reproving him publicly, if a private conference would have served the same purpose.

Departmental conferences similar to the inter-departmental exchange of intelligence just described should be held periodically by the department head. The various members of the department can in turn present the problems of their particular jobs just as the department head has done at the larger meeting. A great advantage offered by these gatherings is the attachment of dignity and importance to every job, no matter

how menial or trivial it may appear to those at the top of the ladder. The worker who feels that he is in on things, who feels that his efforts are of value, who sees his job in relation to other jobs, who has the opportunity to make suggestions that will be considered by his fellow employees at these departmental conferences, is bound to do his bit with an interest and energy that were unknown to him before.

These hospital staff conferences are first-rate places in which to build up a body of common law, as it were, which can then become written law and form a part of the rules and regulations of the institution.

The superintendent should present regular reports to the board of trustees—reports not too lengthy but right to the point, terse, intelligible, not burdened with so much detail that the vital facts are lost in any army of figures or a vast array of words, or so sketchy as to leave the trustees in a state of wonderment as to what it is all about. The superintendent should be present at all board meetings. If the trustees have business so confidential that their chief executive officer must not be aware of it, the stage may be set for his withdrawal at the appointed moment.

Every board meeting is an important episode in the business life of the hospital, and what is done and said at these (preferably monthly) gatherings, should be made a matter of record. The records must be adequate to convey to the mind of the reader what has transpired. They are not mere "reminders," they are serious legal documents of a public character.

For the proper correlation of the administrative, medical and "legislative" work of the hospital, it is desirable to have an active joint committee, with representation on it of members of trustees, the medical board and the superintendent.

Auxiliary Committees Desirable

For the fostering of proper relations with the community, as well as for the support of certain special activities within the hospital, it is desirable to have auxiliary committees of various kinds. The superintendent should be an ex officio member of all of these committees, and it should be a general rule that all employees paid by these auxiliary committees should be under the direction of the superintendent.

Every hospital should be run on a budget basis, each department having allocated to it a specified amount, to which it should firmly and wisely adhere. Stimulated by the chief administrative officer, each department should continuously strive, by a study of the methods of increased produc-

tivity and waste elimination, to bring its cost down to the lowest point consistent with efficiency and proper compensation.

A practical requisition system and a unit cost accounting method are essential in this connection in a large institution. In his book on "Business Administration"* Leon Carroll Marshall points out that "the time has passed when the administrative officer can be in touch with all the details of the business. Cost statistics offer such a man a means of having placed before him at stated intervals a picture, as it were, of his business operations. The administrative officer draws his conclusions from the picture and is afforded thereby a basis on which to found his judgment as to future operations and policies."

Monthly cost accounting units should be studied by the division chiefs and should serve as starting points for investigations and surveys.

Purchasing Policies

Purchasing policies must be guided by local conditions and the existing storage facilities of the individual hospital. The purchase of articles of good quality is in the long run the best policy. Careful inspection, weighing and testing of all articles purchased is of course essential.

Food counts for a great deal in the success of a hospital and must be attractively prepared and protected from waste and pilferage.

Frequent thorough inspection of the boiler room and of the generating plant is a valuable administrative practice.

Last but far from least in any administrative organization is a liberal labor policy. The labor turnover in our hospitals particularly in the lower grade of employees is frightful. It runs up to 600 and 1000 per cent, and sometimes even higher. This means that for every job there are six, ten or more incumbents during the year. To administer an institution efficiently on such a shifting foundation is well-nigh impossible. The hospital should recognize the fact that it must pay its employees wages according to the prevailing scale in the community, and that it must provide those living in the hospital with decent quarters and adequate board. In larger communities a central employment bureau, or at least a central reference office might help to weed out the undesirables, and a liberal wage policy to attract a stabler and more reliable labor force. Bonuses for efficient and loyal work, prize contests of certain types and some method of provision for old age are invaluable aids in increasing interest in the work and reducing the disconcertingly high labor turnover.

*Page 598, "Business Administration," University of Chicago Press, Chicago, 1921.

There likewise should be a liberal policy as to hours of work and as to vacations.

The Hospital Information and Service Bureau of the United Hospital Fund, New York, recently made a study of the vacation schedules of hospitals in New York City. There is a fair degree of uniformity of practice in the hospitals of New York. The vacation schedules reported apply only to employees after they have been with the institutions for at least one year. Superintendents and heads of departments are allowed one month. The usual allowance for graduate nurses is three weeks; all other employees are granted vacation periods of two weeks. Vacation allowances for employees who have served the institution less than one year, are for a period of two weeks in the case of department heads, and one day for every month of service for all others. The vacation schedule operates from June first to October first. The preparation of the schedule should be completed not later than May first, in order that the work may be planned and the hospital run with a minimum of substitutes. Usually the summertime is the dullest season for the hospitals, and with proper planning for rotation of the vacations in each department the work can be carried on with the regular staff, even although their ranks are thinned.

Some hospitals find it desirable to issue from time to time a sheet with hospital news. Such a sheet is useful as a means of spreading institutional intelligence and of helping to create an esprit de corps. In many industrial and commercial enterprises it is found to repay amply the comparatively small cost of publication.

LENGTH OF HEAT TREATMENTS VARIES IN INDIVIDUAL CASES

In Dr. J. C. Elsom's article on light therapy on page 101 of the May issue of THE MODERN HOSPITAL the paragraph at the foot of column one, page 102, should read as follows: "The length of treatment by heat methods varies with the case in hand. In general, it may be said that from ten minutes to half an hour is sufficient. Sometimes longer treatments are indicated but it must be remembered that excessively long treatments are depressing, while short treatments are tonic and exhilarating."

PLAN HOSPITAL INSURANCE SOCIETY

A committee consisting of a number of physicians, members of the Green Cross Society of the Netherlands, has been studying the feasibility of creating a society to insure its members against the cost of a possible future hospitalization. A number of small and isolated enterprises of this nature have already been launched in certain communities. The committee has instituted an inquiry to determine what had been accomplished and with a view to centralizing all previous efforts in this direction.

NEWS OF THE MONTH

NEW STRUCTURE TO BE ERECTED FOR HAHNEMANN HOSPITAL

A campaign for \$2,000,000 for a new structure for Hahnemann Medical College and Hospital, Philadelphia, was launched in April and has been carried to a successful conclusion.

The new building will be erected on the site of the present hospital and will be a sixteen-story structure. When completed it will increase the capacity of the hospital from 415 to 658 beds, exclusive of bassinets. All modern devices will be included in the new hospital which will be an E-shaped structure of limestone and brick. One floor will be devoted to surgery, six floors to private patients, one to semi-private patients and five floors to public patients. There will be no large wards but instead there will be rooms ranging in capacity from two to ten beds, the majority being of six-bed capacity. Three sun rooms will be on every patients' floor.

The cost—\$2,000,000—may seem low to hospital authorities in view of the fact that the building will be sixteen stories high and built in three great wings. The engineers, however, have estimated that it can be constructed for approximately seventy cents per cubic foot. This amount

of money will build two of the three wings. The foundation, basement and ground floor of the third wing will be completed, but no effort will be immediately made to carry it beyond that. The chief reason for building the first two wings to full height is to be able to install elevators properly from the start, obviating expensive changes later.

MR. McNAMARA TO ATTEND MEETING OF BRITISH HOSPITALS ASSOCIATION

John A. McNamara, the executive editor of THE MODERN HOSPITAL will sail June 4 to attend the meeting of the British Hospitals Association, to be held at Norwich, England, June 23 and 24. While in Europe Mr. McNamara will visit hospitals in different parts of France and England and gather data on different methods of hospital administration.

DR. BRODRICK APPOINTED PROFESSOR OF HOSPITAL ADMINISTRATION

Dr. R. G. Brodrick, president of the American Hospital Association, who recently accepted the position of director of hospitals at Stanford University, Stanford University, Calif., has been appointed professor of hospital administration at the university. Dr. Brodrick graduated from Cooper Medical College, and was for several years in the medical corps of the U. S. Navy. From 1908 to 1919 he was connected with the San Francisco Board of Health and from 1914 to 1919 was superintendent of the San Francisco City and County Hospital, San Francisco. For the last eight years he has been director of hospitals of Alameda County.

CONVALESCENT HOME TO BE BUILT BY SHRINERS

A campaign is to be launched this year by the Shriners in the northwest to raise funds for a \$125,000 convalescent home to be built adjoining the Twin City Shriners' Hospital for Crippled Children.

It is planned to start the hospital this year and to have the building large enough to accommodate 200 patients on the waiting list for treatment in the hospital.

NEW DIRECTOR OF A. H. A. PERSONNEL BUREAU APPOINTED

Lillian Kelm, New York, has been appointed director of the personnel bureau of the American Hospital Association, to succeed Zula Morris, resigned. Miss Kelm was at one time connected with the social service department of Bellevue Hospital, New York, and later became director of nurses and assistant superintendent of the Burke Foundation, White Plains, N. Y. She assumed her new duties on May 2.



Architect's perspective of new Hahnemann Medical College and Hospital, Philadelphia.

News of the Month

RECORD ATTENDANCE AT ANNUAL MEETING OF ILLINOIS ASSOCIATION

WITH a registration of close to 200, a new record in state hospital meetings for this year was established at the meeting of the Hospital Association of the State of Illinois, held in Chicago, May 5 and 6.

The attendance at all sessions was the largest that has been recorded at any state hospital meeting and the total registration proved to be second only to Pennsylvania by a small margin. Eighty hospitals were represented and there were approximately 30 per cent of all hospital superintendents in the state of Illinois present at the sessions.

Plans are now under way whereby the members of the Hospital Association of the State of Illinois will receive a service during the year which will make it well worth their while to join this association.

Dr. Paul W. Wipperman, superintendent, Decatur and Macon County Hospital, Decatur, president of the association, opened the morning session at ten o'clock by introducing Reverend J. H. Bauernfeind, superintendent, Evangelical Deaconess Hospital, Chicago, who gave the invocation. Dr. J. C. Geiger acted as a substitute for Dr. Herman N. Bundesen, commissioner of health, Chicago, in giving the address of welcome to the delegates at the meeting. George S. Hoff, trustee, Lake View Hospital, Danville, on behalf of the association, responded.

The first paper presented at the Thursday morning session was entitled "Hospital Costs and Charges" and was given by Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago. He stated that much misinformation was abroad in the land on the matter of hospital charges at the present day. He showed by a deduction of figures that hospital charges were far from exorbitant and that whereas the costs had increased tremendously in the last few years the hospital charges were practically standing still. He stressed the point that hospital superintendents themselves must correct this misconception and must combat erroneous publicity which is being given out to the general press.

Hospital Deficits Discussed

Mr. Bacon's paper was followed by an excellent presentation of facts and figures on hospital credits by Clarence Baum, superintendent, Lake View Hospital, Danville, who went into detail upon the subject and told of his experience at Lake View Hospital. Mr. Baum's paper proved particularly valuable to the superintendents in institutions situated in cities similar to his own.

Frank E. Chapman, director, Mount Sinai Hospital, Cleveland, Ohio, was the last speaker at the morning session, presenting a paper on hospital deficits. Mr. Chapman told of the reason for deficits, their justification, how charges were arranged in his institution, his method of laboratory charges and gave some details generally on hospital financing. His complete presentation of the subject proved to be the feature of the meeting and the value of his talk was appreciated by the superintendents present. He also touched on other administrative problems and told how they had been worked out at Mount Sinai Hospital, Cleveland.

These three papers were discussed by M. R. Kneiff, Marquette University College of Hospital Administration, Milwaukee, Wis., J. W. Meyer, superintendent, Aurora Hospital, Aurora, and E. G. McKay, superintendent, Passavant Hospital, Jacksonville.

Dr. Wipperman at the noon luncheon gave his presidential address, at which time he outlined the future of the Hospital Association of the State of Illinois. While the program that he described was a particularly ambitious one, there was no doubt in the minds of those present that it would be carried out to the fullest extent within the next few years. Divine invocation was asked by Rev. J. L. Anderson, Wesley Memorial Hospital, Chicago.

The first part of the afternoon session was given over to a symposium on legal problems and was divided into two parts. Matthew O. Foley, managing editor, *Hospital Management*, Chicago, gave a review of the existing laws in Illinois and Dr. John A. Lapp, director, National Catholic Welfare Conference, Chicago, spoke on the needed legislation in Illinois. Mr. Chapman then told in his discussion of both papers how proper hospital legislation had been secured in Ohio through the efforts of the Ohio State Hospital Association.

Legislative Committee Urged

Mr. Lapp touched upon workmen's compensation and stressed the point that no hospital had the right to divert its funds intended for free work by giving a lower cost to industry or to the insurance carriers, as was the case in many states. Mr. Chapman told of the workmen's compensation law in Ohio, of the nurse registration law of the state, of the licensing of hospitals and other legislative improvements that are now going on. The result of this meeting was a plea from Dr. M. T. MacEachern, associate director, American College of Surgeons, Chicago, for a strong legislative committee for the Illinois association.

The last half of the afternoon session proved to be a debate upon the advisability of having tuberculosis sanatoriums as a unit of general hospitals, with four tuberculosis authorities presenting their varied views. They were Dr. C. M. Jack, district counselor, Illinois Public Health and Tuberculosis Association and president, Macon County Tuberculosis Association, Decatur, Dr. Robinson Bosworth, superintendent Rockford Municipal Tuberculosis Sanatorium, Rockford, Dr. E. C. Cooley, Vermillion County Tuberculosis Association, Danville, and Dr. W. H. Newcomb, Morgan County Tuberculosis Sanatorium, Jacksonville. This proved to be a most interesting session.

In the evening the banquet and symposium on nurse problems was held. Three nationally known nurse educators were the speakers and E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, presided as toastmaster.

Laura R. Logan, R.N., dean, Illinois Training School for Nurses, Chicago, spoke upon the suggested minimum standards for schools of nursing, Evelyn Wood, R.N., executive secretary, Central Council on Nursing Educa-

News of the Month

tion, Chicago, told of publicity methods and how to secure students, and Dr. May Ayres Burgess, Ph.D., New York, in a most interesting manner, outlined the program of the Committee on the Grading of Nursing Schools. Following this Dr. Wm. H. Walsh, executive secretary, American Hospital Association, Chicago, presented the greetings from the American Hospital Association.

Friday morning's session opened with a paper by Dr. J. J. Moore, director, National Pathological Laboratory, secretary, section on pathology and physiology, American Medical Association, Chicago, on the minimum standards for the clinical laboratory in a hospital. He told of the various routines that were necessary for various cases, he presented facts on the proper set up of the laboratory in hospitals and cited instances where the non-observance of proper laboratory technique had resulted in casualties. His paper was discussed by Dr. MacEachern who outlined the minimum standards as viewed by the American College of Surgeons.

William Gray, pharmacist, Presbyterian Hospital, Chicago, was the next speaker and in a comprehensive paper told of the arrangement of drugs and the duties of the druggist in the hospital. He urged the hospital superintendents and educational directors of hospitals to see that nurses were given instruction in the proper handling of drugs, as well as the interns and resident staff.

Mr. Gray's paper was discussed by Frances Greenwalt, pharmacist, Austin Hospital, Chicago, who spoke on the value of a full-time pharmacist in hospitals, and the close cooperation that should exist between the hospital administrator and the pharmacist.

The last paper was on the minimum requirements for a hospital department of physical therapy and was given by Dr. John Coulter, Chicago. Dr. Coulter was particularly emphatic in his remarks regarding the prescribing of physical therapy treatments and of the need for complete supervision of this department by a medical man. His paper was discussed by Dr. Wm. H. Walsh and Dr. R. W. S. Francis, medical officer in charge, Edward Hines, Jr. Hospital, Maywood.

The afternoon session of the meeting was held at Presbyterian Hospital where Mr. Bacon, by the use of charts and blackboard, told how the staff, the visitors and the patients are admitted and routed through the hospital. After this explanation those present were invited to afternoon tea, several of the department heads acting as hostesses.

Dr. Wiperman Reëlected

Many of the people availed themselves of the opportunity of visiting various parts of the hospital and it was considered that the afternoon had been well spent.

At a business session Dr. Wiperman was reëlected president for one more year and Joe F. Miller, superintendent, Methodist Hospital of Central Illinois, Peoria, who has acted as secretary and treasurer during the past year, was also reëlected. The other officers are: first vice-president, Asa S. Bacon; second vice-president, Macie N. Knapp, superintendent, Brokaw Hospital, Normal; trustees, Dr. M. T. MacEachern, E. E. Sanders, superintendent, Ravenswood Hospital, Chicago, Ada Belle McCleery, superintendent, Evanston Hospital, Evanston, E. I. Erickson, superintendent, Augustana Hospital, Chicago, and George S. Hoff.

The resolutions committee recommended that a report of this meeting be sent to the American Hospital Association and that the American Hospital Association be requested to recognize the Hospital Association of the State of Illinois as one of its constituent organizations. Dr. Walsh, who was present, explained that a movement was now under way for a reorganization of the American Hospital Association's management.

Another resolution asked the board of trustees to appoint a publicity and contact committee composed of Chicago members who would devise means of organized publicity for hospitals and who would be ready at all times to aid members in the state.

SOUTH DAKOTA'S FIRST HOSPITAL MEETING AROUSES INTEREST

The formation of the South Dakota Hospital Association took place at the first meeting of that body held at Huron on May 2, at the Marvin Hughitt Hotel. Dr. R. L. Murdy, Lincoln Hospital, Aberdeen, presided as chairman in the absence of the president, Dr. F. E. Clough, Homestake Hospital, Lead. There were present about forty hospital executives from all parts of the state and the meeting proved to be both interesting and profitable.

The first speaker on the program was Dr. A. G. Allen, Hot Springs, who took as his subject "Hospital Advertising." Dr. Allen spoke in a comprehensive manner of the various methods, all of them ethical, in which the hospital can convey to the public its message of service. He did not advocate promiscuous advertising by physicians or hospitals but told of the value of publicity.

Constitution and By-Laws Presented

A constitution and by-laws were presented by a committee which had been appointed at a preliminary meeting held in March. This was adopted. The second paper of the morning session was presented by Margaret Rogers, superintendent, St. Luke's Hospital, St. Paul, Minn., a trustee of the American Hospital Association. Miss Rogers is also president of the Minnesota Hospital Association and she outlined to the South Dakota Association the advantages and value of both the national and the state association. She told of the activities that had been contemplated by the American Hospital Association. Her paper was discussed by John A. McNamara, executive editor, THE MODERN HOSPITAL, Chicago. He told of the plans that had been made by other associations in holding conventions and what was being done in other states by the organizations and how the hospitals directly benefited by state associations.

Following a luncheon, Dr. Murdy read a paper upon the value of the hospital to its community. He told of the work that the hospital was called upon to do and the many ways in which the institution justifies its existence.

The remainder of the afternoon was taken up with a round table conducted by Dr. M. T. MacEachern, associate director, American College of Surgeons, Chicago. First about fifteen questions were submitted to him by those present and then he proceeded to arouse a general discussion on the problems presented. Cost of administration, purchasing, diets, collections, nursing and many other subjects were thoroughly debated.

News of the Month

It was decided to hold the next meeting in conjunction with the nurses' association, the time and place to be decided by a committee composed of Sister Flavia, superintendent, Sacred Heart Hospital, Yankton, and Mabel O. Woods, R. N., superintendent, Methodist State Hospital, Mitchell.

ADMINISTRATION COURSES TO BE GIVEN AT MARQUETTE UNIVERSITY

Detailed programs for the courses in hospital administration to be given this summer at Marquette University College of Hospital Administration, Milwaukee, have now been issued.

A wide variety of subjects is to be covered in the two courses, the first of which will run from June 6 to June 17, and the second, a six weeks' course, from June 27 to August 6. These courses are offered in response to a constantly increasing demand on the part of individuals in the hospital field who cannot afford to spend longer periods of time away from their duties.

The personnel of the various colleges of the university, particularly the college of liberal arts, the college of engineering, the college of business administration and the medical school, are all to be used for their special contributions to the field of hospital administration, and among the instructors will also be experts in hospital activities from various parts of the United States, including Dr. M. T. MacEachern, associate director, American College of Surgeons, Chicago; Rev. C. B. Moulinier, S. J., president, Catholic Hospital Association, Milwaukee; Michael M. Davis, Ph.D., executive secretary, Committee on Dispensary, New York; Richard E. Schmidt, Schmidt, Garden and Erikson, architects, Chicago; Laura R. Logan, dean, Illinois Training School for Nurses, Chicago; Dr. W. H. Walsh, executive secretary, American Hospital Association, Chicago; Howard Greenman, hospital consultant, New York; Rev. E. F. Garesche, S. J., editorial director, *Hospital Progress*, Milwaukee and C. F. Neergaard, hospital consultant, New York.

The topics to be discussed will include the principles of hospital organization; hospital construction; management of the hospital; problems of standardization; hospital law; institutional investments; community relations; fire protection; hospital records; hospital accounting; mechanical utilities in the hospital and many departmental problems.

All lectures will be held in Lalumiere Hall, 131 Eleventh Street. On Saturday June 11, and on Saturday, June 18, arrangements will be made for demonstrations at a number of the leading hospitals in Milwaukee.

The courses are not given with an idea of obtaining credit and are open to anyone who is interested in hospital work.

SUMMER COURSES AT INDIANA UNIVERSITY ANNOUNCED

During the summer of 1927 short courses, beginning June 10 and lasting for six weeks, will be offered to the physicians of Indiana by the Indiana University School of Medicine at Indianapolis, according to the *Journal of the Indiana State Medical Association*. Features of the course in general medicine will be special courses in physical therapy, biotherapy and drug therapy, using the facilities

of the Robert W. Long Hospital and the James Whitcomb Riley Hospital for Children, Indianapolis.

The course in physical therapy will be available for the first time in Indiana to practicing physicians. The course will be conducted by a graduate physician who has specialized in this field. Practical application of various physical therapeutic agents will be taught by demonstrations and study of cases in the university hospitals, and opportunity will be given physicians to act as practical assistants in this department.

Further information regarding the schedule, the nature of the courses and the fees may be obtained from the Registrar, Indiana University School of Medicine, Indianapolis. Only a limited number of students can be accepted and those who desire to enroll are urged to apply for a registration card indicating the course for which they want their names entered.

COMING MEETINGS

American College of Surgeons.

President, Dr. W. W. Chipman, Montreal.
Director General, Dr. Franklin H. Martin, 40 E. Erie St., Chicago.

Next meeting, Detroit, Mich., October 2-7, 1927.

American Dietetic Association.

President, Florence Smith, St. Mary's Hospital, Rochester, Minn.

Secretary, Quindara Oliver, 25 Marlboro Street, Boston.

Next meeting, St. Louis, Oct. 17-19, 1927.

American Hospital Association.

President, Dr. R. G. Brodrick, University of Stanford Hospitals, San Francisco, Calif.

Executive secretary, Dr. William H. Walsh, 18 East Division Street, Chicago.

Next meeting, Minneapolis, Minn., October 10-14, 1927.

American Occupational Therapy Association.

President, T. B. Kidner, 175 Fifth Avenue, New York.

Sec.-Treas., Eleanor Clarke Slagle, 175 Fifth Avenue, New York.

Next meeting, Minneapolis, Minn., Oct. 10-14, 1927.

American Public Health Association.

President, Dr. Charles V. Chapin, Superintendent of Health, Providence, R. I.

Executive Secretary, Homer N. Calver, 370 Seventh Avenue, New York.

Next meeting, Cincinnati, Ohio, Oct. 17-21.

American Psychiatric Association.

President, Dr. George M. Kline, Department for Mental Diseases, State House, Boston.

Secretary, Dr. Earl D. Bond, Philadelphia.

Next meeting, Cincinnati, Ohio, May 31-June 3, 1927.

American Protestant Hospital Association.

President, Robert Jolly, Baptist Hospital, Houston, Texas.

Secretary-treasurer, Rev. Frank C. English, Christ Hospital, Cincinnati.

Next meeting, Minneapolis, Minn., October 8-10, 1927.

British Hospital Association.

Next meeting, Norwich, England, June 23-24, 1927.

Catholic Hospital Association.

President, Rev. C. B. Moulinier, 124 Thirteenth street, Milwaukee, Wis.

Secretary, Sister M. Philomena, 124 Thirteenth street, Milwaukee, Wis.

Next meeting, Milwaukee, Wis., June 20-24, 1927.

Children's Hospital Association of America.

President, Robert E. Neff, Robert W. Long State Hospital, Indianapolis, Ind.

Secretary-treasurer, Bena M. Henderson, Children's Hospital, Milwaukee.

Next meeting, Minneapolis, Minn., Oct. 12-18.

Minnesota Hospital Association.

President, Margaret Rogers, St. Luke's Hospital, St. Paul.

Secretary, Donald C. Smelzer, Charles T. Miller Hospital, St. Paul.

Next meeting, Duluth, June 24-25, 1927.

National League of Nursing Education.

President, Carrie M. Hall, Peter Bent Brigham Hospital, Boston.

Secretary, Blanche Pfefferkorn, 370 Seventh Avenue, New York.

Next meeting, San Francisco, June 6-10, 1927.

New Jersey Hospital Association.

President, Dr. Paul Keller, Beth Israel Hospital, Newark.

Secretary, Thomas R. Zulich, Paterson General Hospital, Paterson.

Next meeting, Atlantic City, June 7-8.

Western Hospital Association.

President, W. F. Vail, Pasadena Hospital, Pasadena, Calif.

Secretary, C. J. Cummings, Tacoma General Hospital, Tacoma, Wash.

Next meeting, Los Angeles, June 1-3.

News of the Month

HOSPITAL AND INSTITUTIONAL MANAGEMENT COURSE TO START JULY 5

The six weeks' summer session of the hospital and institutional management course of Temple University, Philadelphia, now in its fourth year, begins July 5. The list of members of the faculty for this course includes some well known names, among them are Hon. William J. Ellis, commissioner, department of institutions and agencies, State of New Jersey, who will lecture on the subject of "The relation of a department of institutions and agencies to the hospitals and institutions of the state;" Dr. George O'Hanlon, medical director, Jersey City Hospital, Jersey City, N. J., whose subject will be "The organization and functions of the medical staff," and George R. Bedinger, executive director, Public Charities Association of Pennsylvania, who will discuss "How a public charities association helps the institutions of the state." In addition to these M. P. Burlingame, Bryn Mawr, Pa., Mrs. Marie C. Eden, directress of nurses, Presbyterian Hospital, Philadelphia; D. Adams, business manager, Jefferson Hospital, Philadelphia, and Adeline Pippitt, registrar, Presbyterian Hospital, Philadelphia, will discuss respectively laundry operation and management; the training school; hospital accounting and chart records.

C. S. Pitcher, superintendent, Presbyterian Hospital, Philadelphia, under whose direction the course is given, will present a variety of subjects.

The curriculum is planned to give students a common sense idea of hospital operation, such as will benefit them in their institutional work. Some field work will be included in the course, when methods used by different representative Philadelphia hospitals will be studied. To give a minimum of theory and a maximum of information on practical methods is the aim of this course.

LONDON HOSPITAL RECEIVES GIFTS

Bernhard Baron, who recently gave ten thousand pounds sterling to the London Hospital, London, England, towards the cost of a new pathological department, has now given a further sum of twenty-five thousand pounds to endow it. It has been found that the new department will cost more than was expected, the lowest estimate being fifteen thousand pounds, and the Rockefeller Foundation has offered the additional five thousand pounds without conditions. The governors of the hospital have received another generous gift—the freehold site on which the greater part of the hospital stands, from L. Abrahams.

NEW HOSPITAL FOR TREATMENT OF CANCER IS OPENED IN BOSTON

Another addition to the hospital facilities for the treatment of cancer and other chronic diseases has been made available with the formal opening of the Palmer Memorial Hospital, Boston, on April 20, by the New England Deaconess Association, according to the *Boston Medical and Surgical Journal*.

This hospital is built and equipped to care especially for cancer sufferers, both in the early and advanced stages of the disease. The building with its equipment has cost about \$650,000, and a new nurses' home, to be used also for the New England Deaconess Hospital, Boston, is being

constructed at a cost of \$400,000. An important feature is a large and well equipped pathological laboratory.

In order to make available the facilities of the hospital to more than the seventy-five patients for whom beds are provided, an out-patient department for the diagnosis of tumors and the treatment of ambulatory cases is established. So far as possible, only those patients referred by their family physicians will be admitted to the out-patient department, which will provide expert opinion on tumors for the practitioner and skilled treatment for the patient.

DONATES MEMORIAL HOSPITAL TO PALESTINE

A three-story hospital which will serve as a health center for Palestine has been donated by Nathan Straus, philanthropist, New York, in memory of his wife. When completed, the center will be turned over to the Hadassah, Women's Zionist Organization of America, in charge of public health work in Palestine.

One of the special features of the hospital will be its pasteurization plant for the installation of which \$20,000 has been set aside.

MENTAL DEFICIENCY PROBLEMS TO BE DISCUSSED AT MEETING

The fifty-first annual session of the American Association for the Study of the Feeble-Minded will be held in Cincinnati, Ohio, June 4, 5 and 6, at the Hotel Sinton. The program will include papers on the medical and psychological aspect of mental deficiency, on social service as applied to mental deficiency and on institutional activities. At the dinner session on Sunday evening, June 5, an address will be given by the president, Dr. Benjamin W. Baker, Laconia, N. H. All will be welcome at this meeting, whether or not they are members of the association.

INAUGURATES COURSE IN MEDICAL LITERATURE

A course in medical literature and bibliography was inaugurated recently by the medical college of the Long Island College Hospital, Brooklyn, N. Y. So far as is known this is the first established course of this nature included in the curriculum of any medical school in the country. Charles Frankenberger, librarian, Medical Society of the County of Kings, New York, is the lecturer.

OFFERS COURSE IN MENTAL NURSING

A course in mental nursing is being given at the Boston Psychopathic Hospital, Boston, Mass., and Worcester State Hospital, Worcester, Mass., under the direction of the Massachusetts Department of Mental Diseases, Boston. The course includes formal instruction on various topics and a series of twenty lectures in clinical psychiatry. The object of the course is to develop an understanding of the abnormal mental conditions with which the general nurse comes in contact.

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THE Good Samaritan, as well as many other hospitals of national and international prominence, has accepted Thesco Refrigerators as the solution to their problems of efficiency, sanitation and service in preserving food in its original freshness. Fifty-one refrigerators, designed, manufactured and installed by Thesco, is our accomplishment at The Good Samaritan, one of the country's largest and finest hospitals.

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The porcelain enamel and monel metal exterior of these refrigerators make them the last word in sanitation.

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Methodist Hospital, Memphis, Tennessee.
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News of the Month

WHAT "THE STORK" IS DOING FOR CHICAGO

"The Stork," the luncheon room being run by friends and patrons of the Chicago Lying-in Hospital, Chicago, continues to flourish and is bringing in over \$350 a day, exclusive of tips which run from \$60 to \$100 a day. "The Stork" was started as a novel form of advertising and publicity for the campaign for \$1,250,000 being conducted by the hospital for new buildings, including a mothers' aid pavilion.

Building space, furnishings, staple food articles and special menu dishes are donated to the luncheon room, as are also the services of bank tellers for checking receipts, and of society women and debutantes who supervise arrangements and act as waitresses. There is a hostess for each day in the week, who provides from twenty to twenty-five waitresses from the ranks of the debutantes. The name was chosen by a contest conducted through the newspapers, also a good publicity measure.

The color scheme of the rooms is red, white and black. Clever cartoons in bold black outline, depicting scenes in a maternity hospital, adorn the walls and arouse much interest and comment.

Publicity rather than funds was the primary object of those who sponsored the venture, but happily both of these valuable adjuncts to the hospital's campaign are being achieved. The enterprise will be continued as long as rent-free quarters are available.

During one week in May the energetic women who are leading the efforts of the campaign committee staged another "stunt," taking over the infants' underwear department in one of Chicago's State Street department stores. Ten per cent of all sales made during the week will be dedicated to the hospital endowment. Each day one of the committee was in charge, with ten of her friends as assistants.

OUTLINE OF NUTRITION WORK AT IOWA UNIVERSITY ANNOUNCED

An outline of work for nutrition interns at the University of Iowa hospitals has been announced by Florence M. Ross, head of the nutrition department, State University of Iowa, Iowa City, Iowa. Miss Ross became head of the department last July, succeeding Dr. Ruth Wheeler, who is now on the staff of Vassar College.

This is a twelve months' course and opportunity is afforded to work for a master's degree. A total of thirty credits is required and the candidate must submit a thesis showing an intensive study of a special topic. The plan of the work is so arranged that part of the time is devoted to regular hospital routine and part to classes. The hospital work is of primary importance.

The university hospitals provide full maintenance.

Students may register in the course either July 1 or September 15.

90,000 MILES IN THREE YEARS IS RECORD OF AMBULANCE SERVICE

An idea of the service that a hospital ambulance performs in the course of a year or two may be gained from the distance in terms of miles that the ambulance travels.

Something of a record for distance and endurance is held by the ambulance of the Cincinnati General Hospital, Cincinnati, which has traveled 90,000 miles in three years.

Since the ambulance was placed in service three years ago it has been subjected to hard service, such as long emergency trips and constant service over smooth and rough streets.

ONTARIO DIETETIC ASSOCIATION

The Dietetic Council of Toronto changed its name this year to Ontario Dietetic Association. Though the membership of forty is mainly from Toronto, the intention is to include dietitians of sufficient standing throughout the province who until now have been without professional association.

The present year, September, 1926 to June, 1927, has been very successful. Well attended meetings have been held monthly, usually in the hospitals. Among those who have given addresses are Violet Ryley, manager of the T. Eaton Co., and Eleanor Robertson, whose varied experience abroad resulted in an interesting paper on "Food and Dietetics in Japan." Dr. Almon Fletcher of the University of Toronto lectured on "Diet in Arthritis" and Prof. J. J. R. McLeod on "Diet and Metabolism."

One of the questions taken up during the year is the standardization of courses in dietetics given pupil nurses in the various hospitals. A lecture course is being tried with a view to making the training more uniform.

The officers for the year are:

Honorary president, Prof. A. L. Laird, University of Toronto, department of household science, Toronto; president, C. Hazlett, Christie Street Hospital, Toronto; vice-president, Mrs. C. H. Burns, Toronto General Hospital, Toronto; treasurer, Violet Ryley, T. Eaton Co.; recording secretary, Florence Macdonald, Wellesley Hospital, Toronto, and corresponding secretary, Jean I. Hutt, Hospital for Sick Children, Toronto.

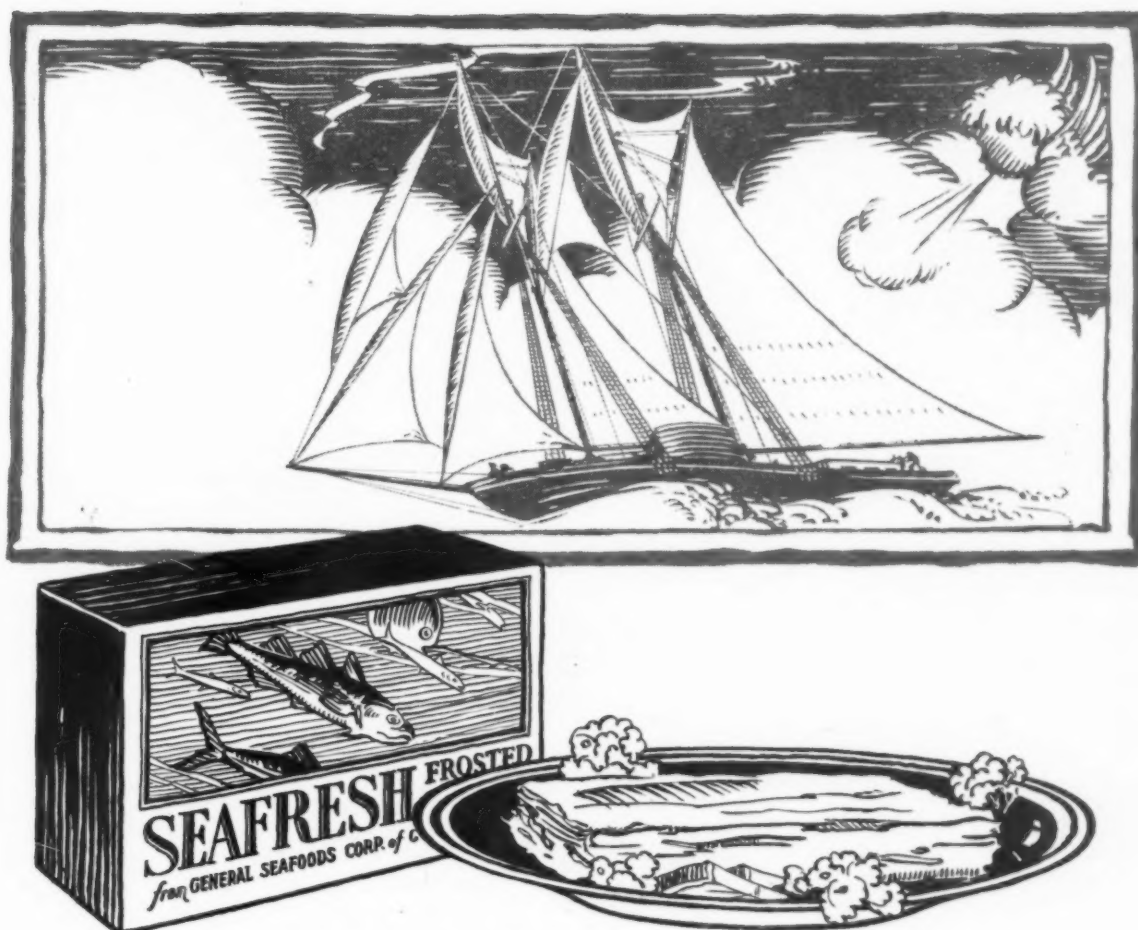
DIETITIANS TO MEET IN ST. LOUIS OCTOBER 17-19

The tenth annual meeting of the American Dietetic Association will be held at Hotel Statler, St. Louis, Mo., October 17, 18 and 19, 1927, according to an announcement from Dorothy B. Richmond, Chicago, business manager of the association. Plans are under way for the program for the three days and it is expected that the tentative program will be ready for announcement soon.

DRAMATIC SOCIETY HELPING TO BUILD HOSPITAL

How a hospital may receive financial aid through local organizations, such as a dramatic association, is exemplified in what is being done for the new Burlington County Hospital, Burlington, N. J., by the Burnt Cork Association, a local amateur dramatic association.

For the past three years the proceeds of the annual play staged by the organization have been set aside for the hospital until now over \$1,000 has been placed on interest toward the building fund of the hospital.



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FRESH Atlantic Ocean fish straight from Gloucester—ready to cook—with a flavor as delicious as if you had just taken it flashing and dripping from the sea!

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Personals

DR. WILLIAM C. MARTINI, formerly medical director, Morgan County Tuberculosis Sanatorium, has tendered his resignation, effective July 1, as medical director of Champaign County Tuberculosis Sanatorium, Urbana, Ill. After July 1, Dr. Martini will be associated with the Palmer Tuberculosis Sanatorium, Springfield, Ill.

DR. ESTELLE H. HENDERSON, medical superintendent, Southwestern State Hospital, Marion, Va., recently died of heart disease, at the age of fifty-five.

DR. WILLIAM A. MCEACHERN, superintendent, Isolation Hospital, Superior, Wis., died recently.

ALICE HENNINGER, superintendent, Seaside Hospital, Long Beach, Calif., has resigned. MISS HENNINGER plans to take a vacation of at least a year before again associating herself with hospital work. The name of her successor has not yet been made known.

HANNAH B. OGDEN has been appointed assistant superintendent of Memorial Hospital, Manchester, Conn., to take the place of HILDA AYERSET who resigned to join the staff of Mount Sinai Hospital, New York.

ALICE F. WALSH, R.N., formerly assistant superintendent of the Malden Hospital, Malden, Mass., is now acting superintendent of that institution.

DR. HOWARD C. VON DAHM has been appointed medical officer-in-charge of the U. S. Veterans' Hospital, Lake City, Fla.

MRS. ALICE A. HILL, Akron, Ohio, has donated \$20,000 to Akron Children's Hospital to complete equipment for heliotherapy treatment.

AMEY ADA has been appointed assistant superintendent of Millard Fillmore Hospital, Buffalo, N. Y.

A. E. WINTER recently assumed the position of assistant superintendent of St. Catherines General Hospital, St. Catherines, Ontario.

CHARLOTTE JANE GARRISON recently resigned as superintendent of the American Hospital, Chicago.

ELIZABETH T. GORMAN, superintendent, Chicopee Falls City Hospital, Mass., died recently, after a short illness. Miss Gorman has been superintendent of the hospital for the past thirteen years.

DR. SMILEY BLANTON, who for the past three years has been director of the Child Guidance Clinic, Minneapolis, Minn., has been appointed professor of child study at Vassar College, Poughkeepsie, N. Y.

NANNIE P. BROWN, Pittsburgh, Pa., recently presented Hillsboro Hospital, Hillsboro, Ohio, with a gift of \$1,000 in memory of her mother.

DR. W. J. HEWSON, a member of the staff of the St. Peter State Hospital, St. Peter, Minn., for the past two years, has been appointed assistant superintendent of the hospital, to succeed DR. GEORGE L. FREEMAN, recently resigned.

LOUIS M. TEFFEAU, formerly of Hurley Hospital, Flint,

Mich., is now superintendent of Michigan Masonic Home, Hospital, Alma, Mich.

DR. S. P. SEBASTIAN, physician to the State Agricultural and Technical College, of North Carolina, is secretary of the newly opened Richardson Memorial Hospital, Greensboro, N. C.

ARTHUR O. BAUSS, superintendent of the Children's Hospital, Akron, Ohio, for the past seven years, resigned June 1. The board announces that no successor has been secured as yet.

DR. I. G. HARRIS, superintendent of the Brooklyn State Hospital, Brooklyn, N. Y., since 1916, and associated with psychiatric and state hospital work for the past twenty-five years, died recently at his home after a prolonged illness.

DR. WILLARD J. HEWSON, a member of the staff, has been appointed assistant superintendent of the State Hospital for the Insane, St. Peter, Minn., succeeding DR. J. F. NORRIS who resigned to join the staff of the Pennsylvania State Hospital.

DR. BERT L. STINSON, Great Bend, Kan., is the new director of the Tangipahoa Parish Health Unit, La., succeeding DR. T. C. W. ELLIS.

KATE LOU LORD, R.N., has resigned the superintendency of the Helena Hospital Association, Helena, Ark., and has become associated with the Methodist Hospital, Hattiesburg, Miss.

MARGARET COPELAND, assistant superintendent, Peter Bent Brigham Hospital, Boston, has been appointed superintendent of the Emerson Hospital, Concord, Mass., to succeed STELLA ORR who is resigning to continue her medical studies at McGill University, Montreal.

DOROTHY S. NEER has resigned the superintendency of the Springfield City Hospital, Springfield, Ohio. Miss NEER has occupied the position of superintendent since 1919.

CHANGE OF ADMINISTRATION AT IOWA UNIVERSITY MEDICAL SCHOOL AND HOSPITAL

Dr. Jesse L. McElroy, superintendent, University Hospital, Iowa City, Iowa, has resigned from the superintendency of that institution. Dr. McElroy will sail, June 4, for an extended visit to Europe where he will make a comparative study of European and American hospital administration.

Other executives connected with the medical school and hospital whose resignations have been announced are:

Dr. C. J. Rowan, head of the department of surgery; Dr. F. J. Rohner, acting head of the department of internal medicine; Dr. L. W. Dean, dean of the college of medicine; Mae J. McArthur, superintendent of nurses, University Hospital; Dr. W. E. Gatewood, professor of medicine; Dr. D. M. Griswold, head of the department of hygiene and preventive medicine.

Announcement has not yet been made as to who will succeed these men in the administration of the medical school and hospital.

WHERE our grandmothers labored with oil lamps, we snap on an electric light. We use a lot of things they didn't know about. We know many things which they didn't know. Because of things they didn't know, they had ideas which to-day we call prejudices.

For instance, they had prejudice against food in cans. We know now, on the word of the greatest scientific authorities, that food in cans is as safe as food can be. We know that the can doesn't harm the food. We know that the sealed, air-tight can is a guarantee of freshness and purity and cleanliness—that we can now get in cans a safer, more convenient and more wholesome supply of food than any people ever before had in the history of the world.

Have you brought your milk supply up to date?

You need to *know* that the milk you use is pure, and fresh, and sweet, and always absolutely clean. You need to know that it contains, always, all the food elements of milk—all the substances which make milk nature's most perfect food. We do know to-day that Evaporated Milk guarantees all these essential qualities. We know that it is one of the modern accomplishments through which science has given us safer, better foods.

Evaporated Milk is pure milk. Nothing is added to preserve it. Not a thing is taken from it but some of the water which is the greater part of all milk. All the food qualities of the milk are kept in it. None of them is harmed in any way.

Always fresh and sweet and absolutely clean. The



You do it differently now

milk is produced under the supervision of experts on farms in the best dairying sections of America. It is received in sanitary plants in the country within a few hours after it comes from the cow—while it is fresh and sweet. It is carefully tested for purity and cleanliness. Then part of the water is removed—it is concentrated. Finally, it is put in air-tight containers and sterilized—protected from everything that can impair its freshness and sweetness and purity. In this condition it comes to your pantry—fresh and sweet and absolutely clean.

With better richness. 60% of the water of cows' milk is removed in making Evaporated Milk. The food (solid) content of Evaporated Milk is, therefore, more than twice as great as in ordinary milk. And *every drop* of Evaporated Milk contains *all* the food elements of milk. There

is no cream line. The cream *never* separates. It stays in the milk. Evaporated Milk is *never* skimmed milk. It is always more-than-double rich in butterfat and *also* in the bone and tissue-building substances—in all the elements which make milk nature's most perfect food.

Wherever you need milk or cream, Evaporated Milk will *better* fill the need.

Undiluted Evaporated Milk serves in place of cream—at less than half the cost of cream. It can be diluted to suit any milk need, and costs less than ordinary milk. Grocers everywhere have it.

Let us send you our free booklets telling you more about the good qualities and varied uses of Evaporated Milk.

The cream begins to separate as soon as the milk comes from the cow.



In Evaporated Milk the cream never separates—it is kept in the milk.

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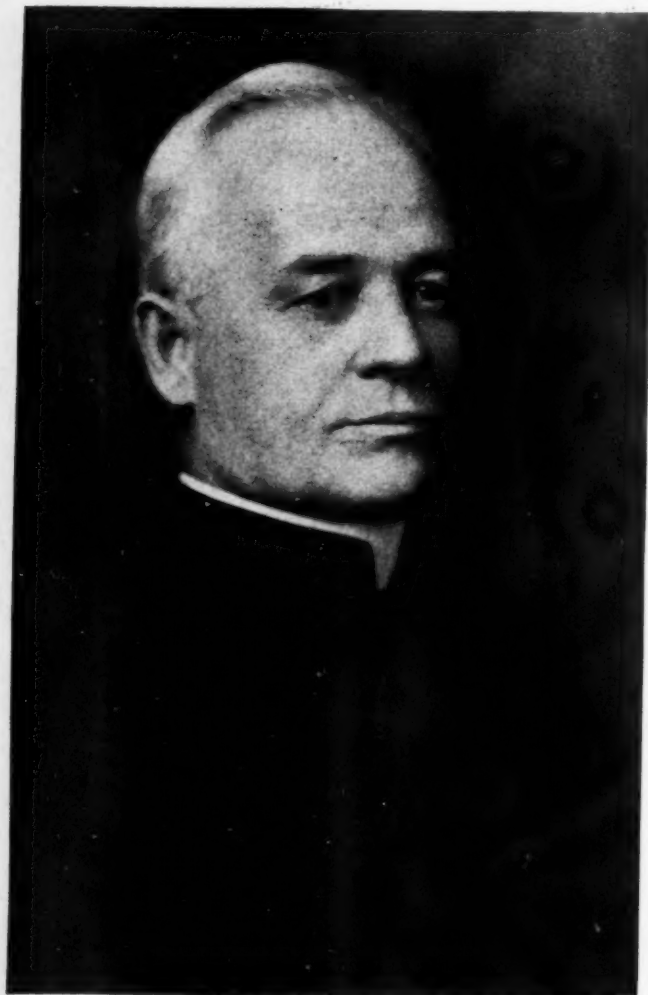
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CHICAGO, ILLINOIS

News of the Month

PLANS FOR MILWAUKEE CLINICAL CONGRESS DEVELOP

The Hospital Clinical Congress of North America, to be held in Milwaukee, Wis., June 20 to 24, under the auspices of Marquette University, Milwaukee, will be the first attempt to institute a practical hospital demonstration of all departments of hospital work. The exhibits will start with the office and receiving room of the hospital and will extend through every department, including radiology, general surgery, minor surgery, obstetrics and pediatrics, physical therapy, and general and pathological laboratory work. There will also be model kitchens, dietary clinics, mechanical equipment and accessories, general housekeeping clinic, laundry and general food clinics. In a separate hall will be a nurses' school and intern service, an outpatient and social service bureau and a photography department.

The congress represents an effort to put the whole hospital layout in each of its departments before the hospital world, demonstrating the most modern advances in hospitalization. The Milwaukee Auditorium, where the exhibits will be is well suited to such a demonstration.



The Rev. Father C. B. Moulinier, S.J., president of the Catholic Hospital Association.

The twelfth annual convention of the Catholic Hospital Association will be held coincident with the Hospital Clinical Congress and the International Catholic Guild of Nurses will meet in Milwaukee at the same time, so that nurses may profit by observing the clinical sessions and may have an opportunity to examine the latest hospital and nursing equipment.

RENAMES STATE HOSPITALS IN INDIANA

The state hospitals for the mentally ill in Indiana have been renamed so that the word "insane" no longer appears in the corporate name of the hospital. For example, the Central Indiana Hospital for Insane has become the Central State Hospital; the Eastern Indiana Hospital for Insane, the Richmond State Hospital; the Northern Indiana Hospital for Insane; the Logansport; the Southern Indiana Hospital for Insane, the Evansville State Hospital and the Southeastern Indiana Hospital for Insane, the Madison State Hospital.

DAYTON'S HOSPITAL NEEDS TO BE SURVEYED

Whether or not Dayton needs another hospital is the major issue to be settled by the survey of the hospitals of that city now being made by the Dayton Research Association, Dayton, Ohio. The survey will take approximately six weeks to complete and it is expected that the results will be made known early in June. Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, is acting in the capacity of consultant to the research group.

HOSPITAL STAFFS GET HEALTH TESTS

The health agencies of San Antonio, Texas, headed by Dr. W. A. King, city health officer, recently conducted a health and clean-up campaign. During the week of the campaign the hospitals of the city provided free health examinations for the interns, nurses, technicians, dietitians, cooks and other employees of the individual institutions, according to Dorothy Morris, executive secretary of the San Antonio Heart Association. Hospitals of San Antonio have made it a rule to require their nurses and other employees to have a physical examination upon entrance into the institution and require similar examinations to be made annually. This practice is regarded not only as a safeguard for the nurses and others but also as a protection for the public.

ENDOWMENT GIVEN FOR CARE OF TUBERCULOUS

A yearly endowment, aggregating \$15,000 to \$20,000, has been given by the Ball Brothers' Foundation of Muncie, Ind., to care for from eight to ten tuberculous patients of Delaware County, Ind., at the Irene Byron Sanatorium, Fort Wayne. This sanatorium was selected for the care of these patients after careful study and investigation of different tuberculosis institutions had been made by the foundation.

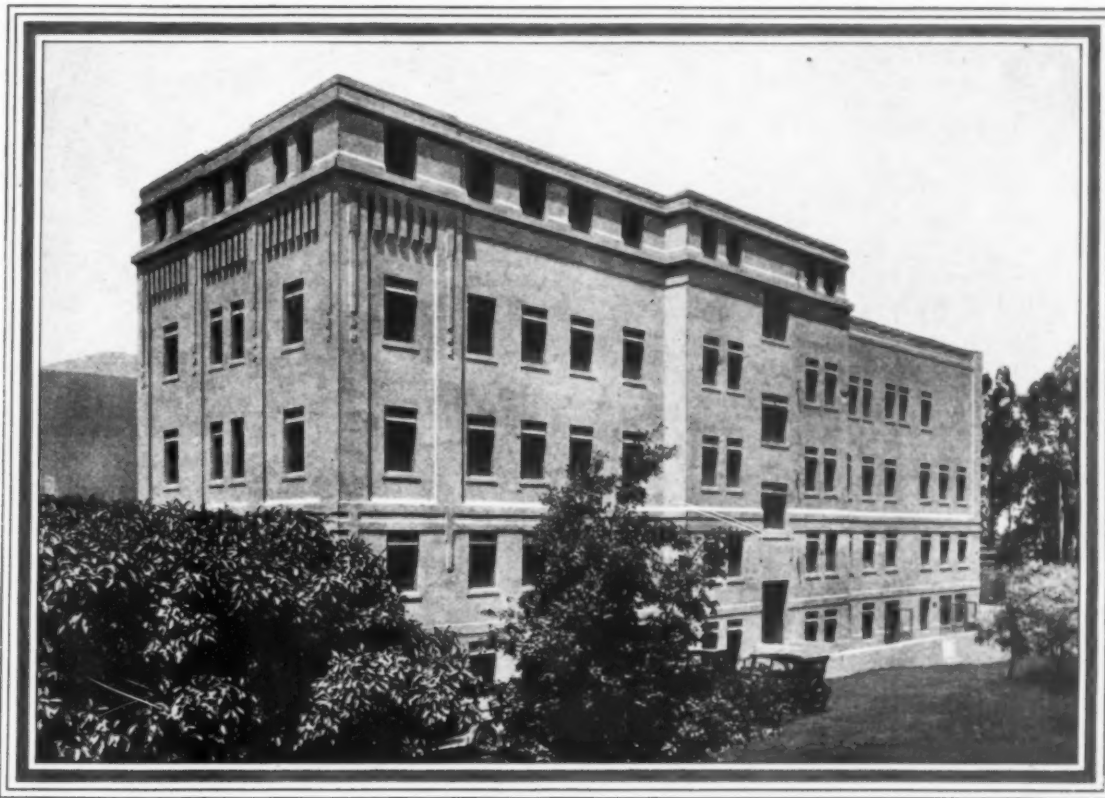
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News of the Month

MOUNT SINAI WILL PROVIDE MODERATE PRICED SERVICE

The trustees of Mount Sinai Hospital, New York, decided at their annual meeting to make provision for private patients with moderate incomes who cannot afford the present cost of private rooms and who do not wish to accept ward service. The original private pavilion of the hospital, will, it is stated, be rebuilt for this purpose.

During 1926 Mount Sinai treated 13,169 patients and provided consultations for 194,203 in the out-patient department. The cost of administering the hospital for the year was \$1,536,565. Legacies and bequests received during 1926 amounted to \$133,834.

TWO PHILADELPHIA HOSPITALS TO MERGE

Definite plans have been made for the merging of St. Luke's Hospital and the Children's Homeopathic Hospital, Philadelphia, and for the construction of a new \$2,000,000 building, to be erected on ground owned by the latter institution. Work on the new building will begin in June.

The reasons for the merger are the need for expansion on the part of both hospitals, a need for economy and a need for training facilities for nurses and medical students. St. Luke's is a hospital entirely for adults and the Children's Homeopathic Hospital is devoted to the care of children and maternity cases. The combined institution will be known as the St. Luke's and Children's Homeopathic Hospitals. Dr. S. S. Goldwater, director, Mount Sinai Hospital, New York, will be the consultant on the new building, which will provide for 300 beds.

HOSPITAL SERVICE TO BE ACCESSIBLE TO ALL CHILDREN IN GEORGIA

A dozen railroads and twenty-five hospitals in Georgia are cooperating with the state board of health in supplying needed medical and surgical attention for rural school children of the state. Children may be taken to the nearest hospital, where they will receive care and treatment for two days at minimum rates.

Railroads have authorized half fare for the parent accompanying the child, and one-half of the half-fare rates for children under twelve years of age. By this plan hospital service becomes accessible to all children, as it has been found that a hospital is within seventy-five miles of every school district in the state.—Board of Education, Washington, D. C.

RHODE ISLAND HOSPITAL OPENS ADDITION TO TRAINING SCHOOL

Aldrich House for Nurses, the \$500,000 building added to Rhode Island Hospital, Providence, R. I., for the housing of its increasingly large corps of nurses, was dedicated April 13.

This is a seven-story structure, with two wings, and will double the capacity of the hospital's nurse training school, which will now be able to accommodate 300 students. Homelike features have been stressed in the arrangements of the building, and every nurse will have her own room, attractively furnished, and with a wall safe for valuables. Five floors are devoted to sleeping

quarters and on each is a solarium for pupils and graduates. Two bowling alleys are among the recreational features of the home.

The addition was made possible through the generosity of Henry L. and Charles T. Aldrich, Providence, who donated a sum of \$500,000 to the hospital for this purpose.

APPROPRIATIONS MADE TO MEDICAL SCHOOL OF INDIANA

Units of the Indiana University School of Medicine, Indianapolis, were given additional appropriations for equipment and maintenance by the 1927 legislature. These included \$75,000 a year for maintenance of the William H. Coleman Hospital for Women, now in process of construction on the campus. This money will become available when the hospital is ready to receive patients. The new unit, which will be a teaching hospital of the school of medicine, will be used exclusively for obstetrical and gynecological cases, and will have bed capacity of approximately seventy-five.

An additional \$10,000 a year was also provided for the operation of the medical school and the Robert W. Long Hospital.

NEW BUILDING OF CHICAGO MEMORIAL HOSPITAL OPENED

The new building of the Chicago Memorial Hospital, Chicago, was opened May 12, when the board of trustees and the medical, surgical and nursing staffs of the hospital gave a reception to their friends, to the medical profession and to the public. After the formal opening patients were received in the new medical, surgical and obstetrical departments.

This hospital has adopted the policy of including the cost of laboratory service in the charge per day to the patient, instead of making a special charge for this service.

BUTTERWORTH NURSES ISSUE ANNUAL

To the nurses of the 1927 class at Butterworth Hospital, Grand Rapids, Mich., goes the credit for issuing the first "annual" ever gotten out by any group of nurses at that hospital. The first issue of "The Voyager" has just appeared, and both in format and in presentation of material is an unusually attractive example of a nurses' annual. The illustrations are varied and delightful. There are beautiful reproductions in sepia of pictures of exteriors and interiors of the hospital; portraits of patrons of the hospital and of its lay and medical staffs; many informal snapshots of nurses at work and on vacation, and black and white outline drawings of the cleverest, making the book a true record of hospital life that will bring back memories to those that shared in it. Interesting text matter relative to the Butterworth Alumnae Association and other matters of interest to nurses is to be found, and a list of Butterworth graduates from the class of 1898 up to the present year is included. The book is well bound in blue leather, with an inset of the exterior of the hospital on the cover.

Annuals of this type help to foster a fine spirit in a school of nursing.

This advertisement, one of a series now appearing in *World's Work*, broadcasts the message that fire can often be stopped at its source—at the doorways, "where fire first breaks through."

World's Work—March, 1927

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For complete index of advertisements refer to the Classified Directory

News of the Month

NURSING CONVENTION TO BE HELD IN SAN FRANCISCO

The National League of Nursing Education will hold its 1927 convention in San Francisco, Calif., June 6 to 10. The convention headquarters will be in the Clift Hotel, which is offering special rates to delegates.

Carrie N. Hall, Peter Bent Brigham Hospital, Boston, president of the league, will speak on "The Part Played by the individual in the Educational Movement." Dr. May Ayres Burgess, director of the Committee on the Grading of Nursing Schools, New York, will tell of the work being accomplished in the grading study, and Effie Taylor, Yale School of Nursing, New Haven, Conn., will speak on "Superintendents and Nurse Assistants." Other speakers will be Stella Goostray, Philadelphia General Hospital, Philadelphia, and Mary Marvin, Columbia University, New York.

A general conference at which Lillian Clayton, president of the American Nurses' Association, will preside will be held to discuss the teaching of ethics.

ST. MARY'S HOSPITAL, CINCINNATI, BROADENS ITS SCOPE

Rooms formerly used as recreation and classrooms for the nurses at St. Mary's Hospital, Cincinnati, have been converted into a children's ward, containing thirty beds. Modern equipment for the treatment of children's diseases has been installed, as well as a radio, toys and other equipment for the amusement of the patients. This is the second improvement that has been added to the hospital since the first of the year. In February a receiving ward was opened and the records show that more than 1400 transient cases have been cared for since that time. It is hoped soon to build a maternity ward, as the hospital has at present no ward for obstetrical cases.

The hospital is managed by the Little Sisters of the Poor of St. Francis Order of Nuns.

HOSPITAL SUNDAY DONATIONS SHOW INCREASE

A sum of \$13,594.87 was raised for Evanston Hospital, Evanston, Ill., through contributions made on Hospital Sunday, April 10. This is an increase of \$2,300 over the 1926 Hospital Sunday contributions to this hospital. The work of the hospital is growing and its needs increasing in proportion to the expansion of Evanston, according to the report of Ada Belle McCleery, the superintendent of the hospital.

NEUROLOGICAL INSTITUTE, NEW YORK TO BENEFIT

A sum of \$200,000 has been given by J. Pierpont Morgan to the Neurological Institute, New York, as a memorial to his wife. The gift will be used for construction and equipment of a complete hospital floor, containing forty-eight ward beds, in the new hospital to be erected by the institute at the Columbia-Presbyterian Medical Center.

Another sum recently bequeathed to the Neurological Institute was a legacy from the estate of the late Dr.

Pearce Bailey, one of the founders of the institute.

The Neurological Institute is unique in that it is the only hospital in the United States devoted entirely to the study and treatment of nervous diseases, according to *Hospital Social Service*. It has been estimated that about 60 per cent of the patients coming to the Neurological Institute for treatment are suffering from functional disturbances.

SYRACUSE HOSPITAL DESIGNED BY NEW YORK FIRM

The new Syracuse Memorial Hospital, Syracuse, N. Y., a detailed description of which appeared in the April issue of *THE MODERN HOSPITAL* was designed by John Russell Pope and Dwight James Baum, associated architects, New York.

Our Monthly Round Table

Can you answer these questions discussed in this issue?

1. Suggest a remedy for the sometimes unjustifiable delay in getting a patient into a hospital. (p. 81)
2. Can the number of vacant hospital beds be reduced? (p. 82)
3. Is the nurse's time being properly utilized? (p. 83)
4. Are superintendents getting the right perspective on their work? (p. 83)
5. Where does the convalescent hospital's responsibility for a patient begin? (p. 85)
6. Are convalescent homes tax-free? (p. 87)
7. How many hospital beds should be set aside for cardiacs? (p. 92)
8. What is the best location for the heart station? (p. 94)
9. How should the metabolic division function? (p. 96)
10. How may laboratory technicians be trained? (p. 97)
11. What is the first principle of hospital administration? (p. 101)
12. What qualities are essential for an executive? (p. 102)
13. How can loss of surgical instruments be prevented? (p. 126)
14. Should a case of scarlet fever make it necessary to quarantine a ward? (p. 128)
15. How is occupational therapy helpful to children? (p. 136)
16. Name points in favor of employment of student nurses. (p. 140)
17. Suggest plan for giving hospital service to ambulatory diabetics. (p. 152)
18. How may colored clothes be safely laundered? (p. 154)
19. Where can psychoneurosis cases best be handled? (p. 90)
20. How much rest and how much exercise should the mental patient take? (p. 91)

MIDLAND TILE-OLEUM

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News of the Month

STATISTICAL REVIEW OF NEW YORK'S STATE HOSPITALS PUBLISHED

The "Report of the New York State Hospital Commission," prepared by Horatio M. Pollock, Ph.D., Director of the Bureau of Statistics, State Department of Mental Hygiene, Albany, New York, has been issued. This annual statistical review of the patients treated in the state hospitals and private licensed institutions for mental disease is made up principally of statistical and classified tables, according to *Hospital Social Service*.

THRIFT SHOP PROVES FRUITFUL SOURCE OF REVENUE

As a source of revenue for the Children's Hospital, Columbus, Ohio, the Thrift Shop, which is conducted for the benefit of the hospital, at 45 East Town Street, Columbus, is proving of considerable financial assistance. The shop sells old clothes, old furniture and old books, the revenue from which goes to the support of the Children's Hospital.

The gross income from the shop during the past year was \$16,000, an increase of \$4,000 over any previous year. This increase was attributed to the resale department of the shop which was started in April, 1926. In this department slightly worn clothing is taken and sold on a commission basis, the Thrift Shop receiving half the selling price and the original owner of the clothing the other half.

Heretofore, the entire stock of clothing sold has been donated, and a large part of it still remains donated. In past years the gross income from the shop has amounted to approximately \$1,000 per month, a sum that is of considerable benefit to the hospital. This is an idea that might be adopted by other institutions.

HOSPITAL SHIP FOR CONGO REGION IS COMPLETED

A hospital ship for the Congo region has been completed and has been christened the *Belgium*, according to the *Journal of the American Medical Association*. It has a length of 32 meters, a breadth of 7.5 meters, and a draft of 75 cm. It has a flat keel adapted for river navigation, as it will ply between ports on the Congo and will render aid, in response to wireless calls, to isolated posts along the river. If an epidemic breaks out at a given point, it is possible to transport within a few hours, or within a few days at most, its physician and nursing personnel and its operating rooms and its pharmacy, with their modern equipment.

"BARTS" APPEALS FOR FUNDS

St. Bartholomew's Hospital, London, England, is appealing for two hundred thousand pounds sterling for the building and equipment of a new surgical building. The scheme comprises ten new wards, five operation theaters and additional accommodation for nurses.

Lord Stanmore, treasurer of the hospital, in describing the scheme at a luncheon given by the Lord Mayor of London, stated that the ward blocks of the hospital were

more than 200 years old and needed drastic reconstruction to bring them up to the scientific requirements of the present day. A five-story building is proposed for these wards. On each floor would be two wards each of twenty-five bed capacity, which would connect with an operating theater on each floor. In the basement there would be an electro-therapeutic department and on the roof, new laboratories.

GIVE \$1,000,000 FOR UNIVERSITY OF CHICAGO HOSPITAL

A gift of \$1,000,000 has been bestowed on the University of Chicago by Mr. and Mrs. John Roberts, Chicago, for the erection of a children's hospital in memory of their son Bobs Roberts, who died in 1917 at the age of five years.

The hospital will be built at Fifty-ninth Street and Drexel Avenue and will be called the Bobs Roberts Memorial Hospital for Children. As the Chicago Lying-in Hospital was recently affiliated with the university, the medical school will be equipped with exceptional facilities for the care of children.

Approximately \$500,000 will be used to build and equip the hospital, which will have 100 beds, according to present plans. The remainder of the gift will be used for endowment. There will be a memorial room in which an appropriate memorial to the son of Mr. and Mrs. Roberts will be placed. The gift makes available to the university facilities for intensive research into the cause, prevention and treatment of diseases peculiar to children.

GENEROUS GIFT TO LONDON HOSPITAL ANNOUNCED

Announcement has been made of an anonymous gift of one hundred sixty thousand pounds sterling to the Middlesex Hospital, London, England, to be used for the erection of a hostel for the nursing staff, on a site adjoining the hospital, according to the *British Journal of Nursing*. At present the nurses are housed in five separate buildings, an arrangement that does not give the necessary comfort or facilities for instruction, recreation or social intercourse.

PREDICTS SYSTEM OF TWIN HOSPITALS FOR ENGLAND

That England is ready for a system of mixed hospitals with paying and non-paying wards, or a system of twin hospitals, one for free and the other for paying patients was brought out by Dr. R. G. Hogarth, president, British Medical Association, in a recent address at Nottingham, in connection with Hospital Sunday.

He suggested that, according to the opinion of experts, the model hospital of the future might be a large central building for urgent cases, with a ring of branch pavilions on the outskirts of the city to which cases might be cleared as soon as they could be moved. Such hospitals, he stated, could be financed by voluntary subscriptions but would have to be organized as never before on a business basis, but should not be run for private profit.



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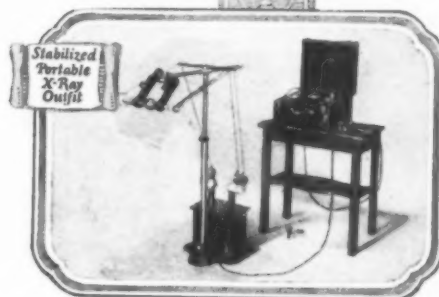
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News of the Month

OPEN DISCUSSION AND PRACTICAL DEMONSTRATIONS FEATURE WISCONSIN MEETING

ROUND tables and open discussions of current hospital problems were the features of the seventh annual meeting of the Wisconsin Hospital Association held at the Pfister Hotel, Milwaukee, May 23 and 24.

The meeting from every standpoint was a success and the attendance was greater than that at any other Wisconsin meeting. There was a minimum of prepared papers and a maximum of open discussion from the floor, which gave an added value to the several sessions held. Another innovation this year was the many hospitals that were visited and the practical demonstrations that were given in these institutions. Nearly every hospital in Milwaukee was a Mecca for the delegates, and both afternoons were left open for these visits.

The meeting was opened by the Rev. Herman L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee, the president of the organization since its inception, on Monday morning, following the registration. Mayor Daniel Hoan of Milwaukee welcomed the delegates to the meeting and President Fritschel read his annual address. In this speech he reviewed the work that had been done by the association and surprised those present by definitely stating, that due to the pressure of other work he would be unable to serve as president any longer should the honor be offered him.

Mr. Fritschel's address was followed by the report of Secretary H. K. Thurston, Jackson Clinic, Madison, and also the reading of the treasurer's report by Mr. Thurston. Both reports showed the association to be in an excellent position and reflected credit upon its able secretary.

Physical Therapy Facts Explained

The first paper to be presented was by Dr. J. C. Elsom, professor of physical therapy, University of Wisconsin Medical School, Madison, on "Physical Therapy in a Hospital." Dr. Elsom pointed out many facts that must be faced by every hospital when it adds a physical therapy department, and gave warning of the pitfalls that would defeat the purposes of physical therapy if this department were not instituted under proper guidance. His paper was discussed by several of those attending, the discussion being led by Dr. Robert S. Ingersoll, superintendent, Madison Sanitarium, Madison, and by E. P. Bodelson, physical therapist, Mount Sinai Hospital, Milwaukee.

Mr. Fritschel introduced to the delegates Dr. Donald C. Smelzer, superintendent, Charles T. Miller Memorial Hospital, St. Paul, Minn., who is also secretary of the Minnesota Hospital Association. Dr. Smelzer brought the good wishes of the neighboring association and on behalf of his association invited the members of the Wisconsin Association to attend the Minnesota meeting to be held June 23 and 24 at Duluth.

Harry Halfacre, manager of the Pfister Hotel, delivered a talk on the hospital as viewed by a hotel man. He pointed out many of the similarities of hotel and hospital administration and explained some of the methods that were being used at the Hotel Pfister. Following his talk Mr. Halfacre was the target for numerous questions, and

he remained at the session answering questions throughout the round table that followed, which was conducted by Dr. W. A. Henke, chief of staff, Grandview Hospital, La Crosse.

At the close of the morning session the delegates accepted the invitation of Mr. Halfacre and made a tour of inspection of the hotel.

In the afternoon visits were made to the Milwaukee Children's Hospital, the Evangelical Deaconess Hospital and Mount Sinai Hospital.

Nursing and Social Service Discussed

An interesting program was presented on Monday evening, when nursing and social service were both ably discussed. Cornelia Van Kooy, R.N., president of the Wisconsin State Nurses' Association, told of the strides that were being made in nursing throughout the state, and Adda Eldredge, director of nursing education, State of Wisconsin, Madison, discussed the paper. Aubrey W. Williams, general secretary of the Wisconsin Conference of Social Work, Madison, read a paper on "The Social Service Aspect of the Hospital." This was discussed by Grace T. Crafts, R.N., superintendent, Madison General Hospital, Madison, and Millie A. Jacobson, R.N., superintendent, Luther Hospital, Eau Claire.

On Tuesday morning two papers were read, the first "How Shall We Collect Hospital Bills?" by Robert R. Aurner, assistant professor of business administration, school of commerce, University of Wisconsin, Madison, and the second, "How to Reduce Cost of Hospital Service," by L. Austin, superintendent, Mount Sinai Hospital, Milwaukee. Mr. Aurner outlined the general principles of collection in industry and trade and then applied them to hospitals. The use of collection agencies, the abuses of collection agencies and the methods that might be pursued in getting delinquents to pay were brought out. The discussion under the leadership of Charles F. Karrow, superintendent, Columbia Hospital, Milwaukee, and C. I. Wollan, superintendent, La Crosse Lutheran Hospital, La Crosse, was interesting and presented many ideas upon this vital topic.

Mr. Austin detailed the factors that go toward making hospital costs, quoted the editorial in the March issue of *THE MODERN HOSPITAL* upon costs and charges, and then proceeded to outline some economies that should be practiced in hospital administration. His paper was discussed by Mr. Wollan and by Dr. John G. Meachem, president, Alice Horlick Memorial Hospital, Racine. These two papers were followed by a round table conducted by Dr. R. C. Buerki, superintendent, Wisconsin General Hospital, Madison.

At the business session Dr. Henke was elected president; Grace Crafts, first vice-president, and Levina S. Dietrichson, superintendent, Rocky Knoll Sanatorium, Plymouth, second vice-president. Mr. Thurston was reelected secretary and treasurer. Rev. Mr. Fritschel was elected to the board of trustees and was also named as a delegate to attend the Minnesota meeting at Duluth. Four names

RESTORING THE SICK TO HEALTH AND KEEPING WELL PEOPLE WELL

This double function—*keeping well people well and restoring the sick to health*—is one of the reasons why the hospital idea has been so universally accepted by the American people.

Restoring the sick to health, while originally the only function of the hospital, is more and more being supplemented by the service of *keeping well people well*, and all over the country hospitals are taking active leadership in health educational work.

Quite properly the service of any hospital includes educational work with resident patients, out-patients, and through its community contacts—educational work to the end of preventing those abuses of right living which lead to ill balanced metabolism which so frequently shows itself through a diminished alkalinity of the blood and tissues due to an excess of acid products—*acidosis*. This excess acid is frequently observed for the first time when the patient enters the hospital or dispensary for diagnosis. It is the beneficent service of the hospital staff to go beneath the surface of things and find out the underlying causes.

Whatever may be the remote cause of hyperacidity, the simple corrective measures here discussed should be considered by those re-

sponsible for the diagnosis, treatment and care of patients in hospitals and similar institutions. Also a note of warning may well be sounded to those who are well so that they may conserve health.

Gastric hyperacidity, acidity of the mouth and other of the more obvious manifestations of acidosis are promptly counteracted by Phillips' Milk of Magnesia which has a pronounced affinity for acids, the harmless resultant compounds being readily excreted.

The increasing use of sodium bicarbonate by the public to control "acid stomach" should be considered in this connection. Only a part of the bicarbonate is effective and that portion which produces carbon dioxide may be seriously detrimental.

Phillips' Milk of Magnesia being free from carbonates does not distend the stomach nor cause flatulence of the lower intestinal tract. Its antacid action is pronounced. A given quantity of Phillips' Milk of Magnesia neutralizes almost three times as much acid as a saturated solution of sodium bicarbonate and nearly fifty times as much as lime water. Further it has the additional merit of being laxative, a quality of importance here since constipation is so frequently the underlying cause of hyperacidity.

DOSAGE—The usual dose of Phillips' Milk of Magnesia, as an antacid, ranges from one teaspoonful (4 c. c.) to one tablespoonful (16 c. c.). This amount should be mixed with an equal portion of cold water or milk and given half an hour after meals.

For its laxative effect, the adult dose is one to two fluid ounces (30 to 60 c. c.). The aperient action may be facilitated by giving the juice of lemon, lime or orange, half an hour thereafter.

PHILLIPS' Milk of Magnesia

CAUTION. Beware of imitations of Phillips' Milk of Magnesia. The genuine product bears our registered trade-mark. Kindly prescribe in original 4-ounce (25c bottles) and 12-ounce (50c bottles) obtainable from druggists everywhere.

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For complete index of advertisements refer to the Classified Directory

News of the Month

will be submitted to the state board of health from which one member of the board of nursing education will be selected. The four so honored were: Mr. Karrow, Mr. Wollan, Mr. Thurston and Dr. R. C. Buerki,

In the afternoon visits were made to Columbia Hospital and the Milwaukee Hospital.

The banquet in the evening proved to be a distinct success. J. A. Yockey acted as toastmaster and there were five speakers. Dr. M. T. MacEachern, associate director, American College of Surgeons, Chicago, was the first on the program. He told of the work that the College of Surgeons is doing among hospitals, emphasized the fact that there was great value to be gained by keeping a close contact with the publications serving the field, and urged the people to attend both the clinical congress to be held at Milwaukee on June 20 to 24, and also the meeting of the American Hospital Association at Minneapolis in October.

Judge A. C. Backus, a publisher of Milwaukee, was the next speaker. He enumerated statistics on hospitals and health work and told those present of the needs in Milwaukee for better hospitalization. He was followed by Father C. B. Moulinier, president of the Catholic Hospital Association, who endorsed the splendid address of Judge Backus and also stressed the point that better hospitals, better nursing and better health work were the things that were needed.

John A. McNamara, executive editor THE MODERN HOSPITAL, was the next speaker. He complimented the people of Wisconsin upon their good fortune in being located in the center of the convention activities and stated that he hoped they would all take advantage of the opportunity to attend the clinical congress in Milwaukee in June, the meeting of the American College of Surgeons in Detroit during the week of October 3, and the meeting of the American Hospital Association in Minneapolis, October 10 to 14. He also stated that they were indeed fortunate in having such a citizen as Judge Backus who was so well versed in hospitalization and in a position to be of so much help to all hospitals through the columns of his paper.

Dr. William H. Walsh, executive secretary, American Hospital Association, Chicago, was the last speaker. He asked the people to attend the meeting at Minneapolis.

VARIED PROGRAM PRESENTED AT METHODIST MEETING

Two meetings held in Atlanta, Ga., April 19 and 20, are significant in the development of Methodist hospitalization.

The Hospital Association of the Methodist Episcopal Church, South, held its second annual meeting, April 19, at the Wesley Memorial Church, Atlanta, Ga. The founder and president of the association, Dr. C. C. Jarrell, Atlanta, Ga., arranged a varied program which featured an address by the president on hospital progress in southern Methodism during the last year, showing nearly \$2,500,000 of hospital property going into service; an address by Lake Johnson, superintendent, Good Samaritan Hospital, Lexington, Ky., on "Tendencies in Nursing Education" and a paper by Dr. L. H. Burlingham, superintendent, Barnes Hospital, St. Louis, Mo., on "The Problems

of the Hospital Superintendent." Other topics discussed were "Raising Hospital Funds," "How to Keep the Hospital Out of Debt" and "Methodism and Health."

At the dinner session Dr. J. L. Campbell read a paper on "Methodist Hospitals and Medical Education."

Dr. C. C. Jarrell was reelected president and Dr. F. W. Brandon, secretary.

Another meeting of interest in Methodist hospital circles was the meeting of the General Hospital Board of the Methodist Episcopal Church, South, held April 20. The president of the board, Bishop Warren A. Candler, was in the chair, and the general secretary, Dr. C. C. Jarrell, read the annual report, which showed marked progress in the hospitals of the Church. Since the board was organized in 1922 something like three and one-half million dollars have been added to the hospital properties of the Church. Total hospital properties now amount to more than eight million dollars.

CONFERENCE CALLED TO CONSIDER STANDARDIZATION OF LINENS

At the request of the American Hospital Association's committee on general furnishings and supplies, of which Margaret Rogers, superintendent, St. Luke's Hospital, St. Paul, Minn., is chairman, the division of simplified practice of the U. S. Department of Commerce has called a general conference to consider the committee's simplification recommendation covering the most important items of hospital linens.

The conference will be held at the Department of Commerce, Washington, D. C., June 10. Invitations have been issued to manufacturers, distributors and users of the items under consideration.

This conference is the result of the survey of hospital linens recently made by the committee on general furnishings and supplies, in an effort to eliminate waste.

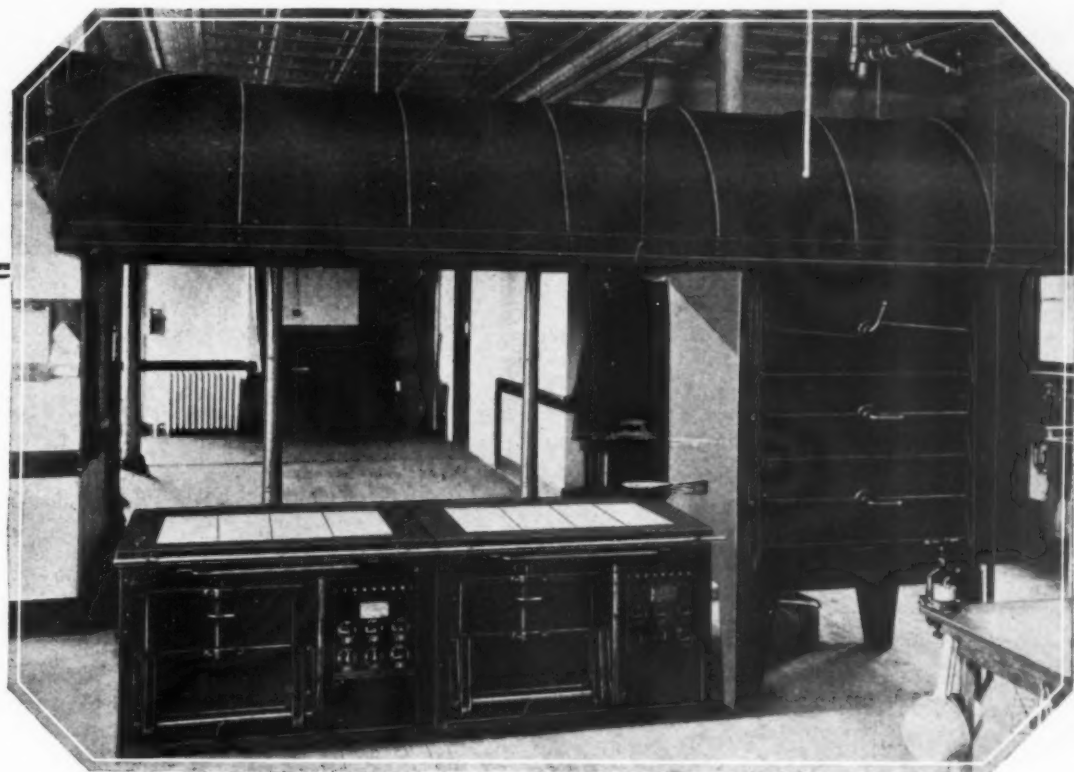
WASHINGTON UNIVERSITY TO HAVE RADIOLOGICAL INSTITUTE

One million dollars has been donated to Washington University, St. Louis, by the Malinckrodt family of St. Louis and the general education board of the Rockefeller Foundation. The money has been given for the establishment of a radiological institute, and will enable the medical school to establish in St. Louis an important center for the study of cancer.

The new institute will be named the Mallinckrodt Radiological Institute and will be located in the Washington University group of schools and hospitals at Kingshighway and Euclid Avenue, where it will be easily available for students and for patients at Barnes Hospital, the St. Louis Children's Hospital and the St. Louis Maternity Hospital which will be opened in June.

One fourth of the money will be spent for the building and the remainder will be used as an endowment.

The study of cancer will be the institute's primary purpose but its work will include also the study of the diagnostic and therapeutic uses of the x-ray and of those new artificial rays of greater power than the x-ray whose curative qualities are not yet defined.



Why An Electric Kitchen?

1. **It is cleaner.** No coal, ashes, smoke, fumes, gas.
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4. **It saves** in space, building cost, maintenance and insurance.
5. It requires **less attention** in use.



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RANGES

YOUR EVERYDAY PROBLEMS

A department devoted to the informal discussion of problems arising in the everyday life of the hospital superintendent.

[No attempt has been made to offer final conclusions relative to the questions considered in this department. THE MODERN HOSPITAL will gladly welcome further comment by its readers on any of these problems, or the presentation of other queries for discussion in later issues.—Editor.]

How Many Hospital Appointments Shall Members of the Visiting Staff Hold?

This problem has been often presented to members of boards of trustees of hospitals. A certain kind of physician appears desirous of securing as many hospital appointments as possible, indeed, more hospital appointments than he can properly attend to.

If the institution be a large public hospital in which no private rooms are available, it would be obviously unfair to restrict the members of its visiting staff to but one appointment. This is true because every physician must, for obvious reasons, have entrée to private rooms in order to care for his patients who require hospitalization. Again, a hospital may not possess these facilities in sufficient degree so that all the members of its visiting staff can secure private rooms when their patients require them.

It seems that if a hospital forbids its visiting physicians to hold more than one appointment, it must also provide those physicians with the room facilities that they require.

In most cities, it is the custom for physicians to send some of their patients to small private hospitals which possess no ward service, and which, therefore, do not exact from these physicians any free service to this type of patient.

The crux of the situation seems to lie in whether the members of a visiting staff are able to devote as much time as seems necessary to the patients of their hospital, or whether they manifest a tendency to scant the time spent in the hospital and to delegate the care of ward patients to their assistants or to resident physicians. The hospital, without doubt, has the right to rule as to the amount of time each of its staff should devote to the care of its patients, but it cannot definitely regulate the interest and support that it should receive from these physicians. It would be a fine thing if each hospital could insist that all of the time which its staff is able to devote to institutional medicine, be given to it, and this is the case in some hospitals.

In the institution with a full-time paid staff this problem, of course, does not arise. Nor is it likely to be as troublesome in the institution that does not pay a salary to its staff, but permits its members to have office facilities within the hospital. This has been found to be a workable scheme in not a few instances.

No rule, therefore, can be set as to the number of appointments staff physicians should accept. This will depend largely on the size, nature and clientele of the specific hospital. However, where a physician finds it impossible to see all of his patients at frequent intervals because of

other appointments, or where boards of trustees learn that a physician is not attending monthly conferences because of engagements elsewhere, the offending physician should be clearly informed by the board of trustees that if his other institutional engagements prevent his devoting sufficient time to their hospital, it would be better for him to choose the hospital upon the staff of which he would prefer to serve.

Nevertheless, it should be remembered that a large part of the physician's income, particularly if he is a surgeon, is derived from the treatment of members of his clientele in hospital private rooms. On the other hand, the free treatment of ward patients and the other services that the hospital receives from its chiefs, are their return for the privilege of using the institution's private floor. The board of trustees certainly has a right to regulate this matter definitely.

Is Mechanical Painting Possible and Efficient in the Hospital?

The executive who asks this question no doubt refers to the application of paint by means of compressed air.

There are few institutions in which the superintendents are fully satisfied with the freshness of the paint of walls and furniture. It has been stated that a painter is performing a fair day's work, if he is able to cover with paint from three hundred and fifty to five hundred square feet of surface daily. Many executives find that the hospital's budget does not permit the employment of a sufficient number of painters completely to cover the hospital's inside and outside walls, at least, every two years, and all of its furniture at a much more frequent interval.

In some localities, ingenious executives have devised a type of apparatus with drying kilns, for the painting of hospital furniture by dipping, but the tediousness and time consuming application of three coats of paint to walls, ceilings and floors, makes it impossible for the hospital to present the neat appearance that new paint brings.

There are diverse varieties and types of apparatus for the application of paint by compressed air. Indeed, many instrument firms, automobile manufacturers, and other industrial concerns depend entirely upon this method of painting.

With a proper apparatus, it has been proved that paint can be thus applied much more rapidly, and almost as efficiently as with the hand brush.

Painters of the old school are not in favor of this innovation, possibly because they feel that it will result in a general adoption of this practice, and the consequent elimination of their occupation. To this argument, there is no basis, because window work and other types of detail painting must be done by hand. Moreover, it has been found that one man and a compressed air apparatus, both of which are functioning properly, can do the



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Professor SAMUEL C. PRESCOTT, of the Massachusetts Institute of Technology.
Scientific Monthly, Volume 6, p. 74

At all seasons, by itself or in combination with milk, in salads, with the leafy vegetables and other fresh fruits the banana furnishes the needed carbohydrate calories.

In the winter months especially, bananas provide the vitamins and mineral salts particularly needed in a diet often too low in green vegetables and fresh fruits.

To these qualities "this remarkable fruit" brings the added value of a nutritious, energy-producing staple food, of first importance to all in the selection of an appetizing, strength-giving diet.

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work of from three to five painters using the brush. An ordinary bedside table or chair can be painted in from three to five minutes, giving time for altering its position as the process requires. A comparison of this length of time with that required for hand painting will show much saving.

Adequate measures of prevention have been devised in order to avoid an increase of the industrial hazard, from the standpoint of lead poisoning. The user of the compressed air machine no doubt should wear a suitable respirator. One superintendent, upon observing the floor of a ward, in which compressed air painting was being done, was covered with a white powder, had a chemical examination of this substance made, and found that it contained no trace of lead, but that it consisted of magnesium and calcium, which are commonly used as fillers in the manufacture of flat wall paint. The inhalation of this dust would not be likely to cause serious harm to the health of any one. This superintendent also found that when walls were being painted much less of this powder on floors was seen than when the ceiling was being painted, the force of gravity no doubt being responsible for this difference.

The apparatus required ranges in price from four hundred to seven hundred dollars, but the saving in time, which results from its use, would appear to be ample justification of this expenditure.

Some waste of paint no doubt results, but this increase in expense for paint will not counterbalance in any way the saving of time, the measure of which has been suggested above.

Is There Any Way to Prevent Loss of Instruments in the Hospital?

The superintendent who asked this question writes that upon assuming his new duties as executive of a hospital he found on his desk a list of instruments which had disappeared from the operating clinic. He was aghast to learn that no one knew where the instruments in question had gone, nor did any one appear to be particularly disturbed at their disappearance, expecting that he would immediately replenish the supply with new articles. Upon further inquiry, he learned that this disappearance of instruments was not an uncommon happening in this hospital.

This has been the experience in a measure of more than one hospital executive. Various methods have been adopted to learn the reason for this loss, and to prevent its recurrence. A properly kept inventory, with a rigid insistence upon a receipt for instruments which are borrowed from the clinic, is the first step to be taken. The announcement of a new policy to the nurse in charge, that is, that the instruments which are lost must be replaced, or the money for such replenishment turned over to the directress of nurses, will have a salutary effect in lessening this loss.

To be sure, it is not fair to require the nurse (who is receiving for her services one hundred dollars per month, or less) to pay for instruments lost in the course of a day's work through no fault of hers, but on account of the carelessness of others. The superintendent of the hospital, however, must be the judge as to whether to remit this payment or not.

Sometimes a curious attitude toward the ownership of the institution's property is assumed by members of the hospital personnel. But if it becomes generally known that the nurse is to be held responsible for the replacement of instruments that are removed from the operat-

ing or dressing rooms, and not returned, there are few persons who would permit her to pay for articles in the disappearance of which she was in no way concerned.

Not a few executives have found that the adoption of this simple method has gone a long way toward solving this troublesome problem.

What Is the Obligation of the Hospital to a Student Nurse Who Develops Tuberculosis?

This is a question that is troubling a number of hospital superintendents and directresses of nurses throughout the field.

A satisfactory solution of this problem can not be forthcoming unless one considers the manner in which pulmonary tuberculosis develops. It is felt by almost all clinicians that tuberculosis is not contracted by a transient exposure, in the same manner in which other diseases, such as contagions, develop. When one considers that in a very large percentage of postmortem examinations, a previous, but healed, infection with the tubercle bacillus, is found, one realizes the importance of the role that virulence and resistance play in the incidence of this disease.

The student nurse, upon entrance to a school for nurses, may display no evidence of a pulmonary infection. She may or may not have a family history of this disease, but because of the nature of her work, and a waning of resistance on her part, as a result of loss of sleep or excess of fatigue, she may light up an old lesion whose presence was not detected one or more years previously.

In such a case, should the hospital stand the expense of her care in a sanatorium, provided her family's finances are not such as will easily meet this outlay? Most hospital superintendents believe that the time to prevent this accident, if possible, is when the student nurse is admitted to the school. If, for any reason, a tuberculous tendency is not detected then, and if the nurse should develop tuberculosis during her course of training, it is usually felt that the hospital should stand the expense of sanatorium treatment for her ailment.

Another factor, which may effect the solution of this problem, is the length of time that the nurse has served before she became ill. If this period is a short one, what limit should be set as to the length of treatment for which the hospital is responsible?

This angle of the question would appear to be one of degree of responsibility, rather than of the existence of the principle. Compensation laws, in force in various states, appear to point to the existence of this responsibility by the hospital, although it is impossible to prove or disprove that the development of the pulmonary infection would or would not have occurred had the individual not been undergoing a strenuous course in training. However, the fact remains that a disability occurred during this period, and this fact does not seem to nullify the hospital's responsibility in the matter.

Is it Unwise to Use the Institutional Ambulance in the Performance of Errands?

The answer to this question will depend somewhat upon the size of the hospital, and the motor equipment which it possesses. Most hospitals own utility conveyances for the performance of such work.

The construction and equipment of the hospital ambulance is such that it does not easily lend itself to the transportation of express and freight packages of size, or of those materials and supplies that will mar and soil the interior of the ambulance. The appearance of the

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Equips new Beaumont Building in St. Louis
with this material that stops X-rays

THROUGHOUT the radiological and therapy departments of the new Beaumont Building, Dr. Ernst—President-elect of the Radiological Society of North America—has used Barium Sulphate Plaster to stop X-rays and the gamma rays of radium.

This remarkable plaster has well demonstrated its ability to stop these powerful rays. X-ray rooms in many hospitals and doctors' offices are being lined with it.

Barium Sulphate Plaster forms an impenetrable barrier to X-rays—a barrier unbroken by any joined surfaces or cracks. No rays can leak through into adjacent rooms. Plates may

be safely stored within easy reach of the X-ray installation.

Barium Sulphate Plaster combines appearance with absolute protection. It can be painted without difficulty. It is applied just as ordinary wall plaster is applied. And it is less expensive than old methods of protection.

Write for the formula. The right mix is of first importance. Upon request we shall send the formula for mixing the barium sulphate, the barium sand and cement in just the right proportions. (Process patented.) We include an installation license free of charge when the barium products are purchased from us.

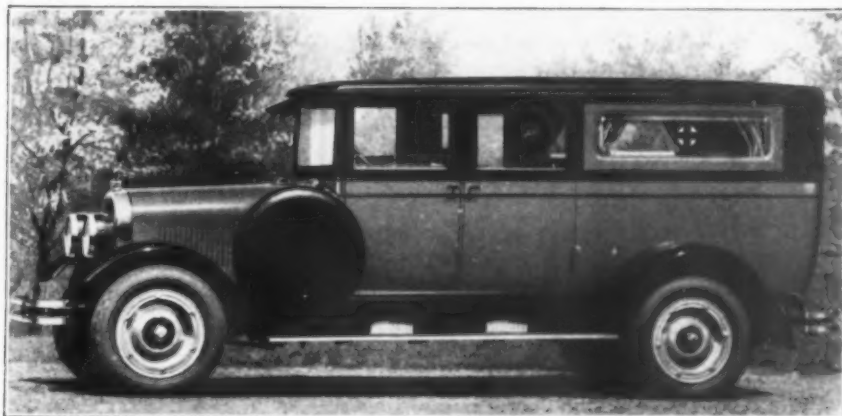
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EVERY once in a while we meet a hospital superintendent who has the impression that the initial cost of Sayers & Scovill ambulances restricts their use to only the largest institutions. But it's an impression without foundation, as you'll see from The Aberdeen.

This ambulance, in every detail a typical S&S car, is priced at \$3,750—not a great

deal more than you would pay for many ordinary ambulances. And, designed as a unit—body and chassis built together to work together, it will give you performance which no compromise car can duplicate.

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The Sayers & Scovill Company

Established 1876

Gest and Summer Sts., Cincinnati, Ohio

ambulance on the street should signify that it is on an errand that has as its object the transportation of patients.

It seems much better for the hospital to possess a small passenger car or truck for the carrying out of these errands, than to utilize its ambulance for this purpose. It may be added that the appearance of the ambulance and the dignity of the driver and the physician who accompanies it, has much to do with the public's opinion as to the hospital itself.

If a Case of Scarlet Fever Develops in a Women's Ward, Should the Ward Be Quarantined?

The answer to this question must depend somewhat upon local public health regulations. Our attitude toward the transmissibility of this disease, from the institution's standpoint at least, has been much changed since it has been demonstrated that scarlatina is caused by the streptococcus. It is well known that adults are less susceptible to scarlet fever than are children. It is also believed by most physicians that transmission of scarlet fever is brought about by the direct transference of germs from the sick to the well, by means of soiled hands, garments, and other intermediary objects.

In some of our larger cities, fumigation is being discarded as useless in preventing the spread of this disease, the doctrine of soap and sunshine having superseded this practice.

In not a few instances, a case of scarlet fever has been removed from an adult ward, and after having fumigated the mattress and having scrubbed the walls, bed, and other articles of ward furniture, with which this patient had come in contact, the work of the ward has proceeded as if nothing had happened. No secondary case has developed in one institution in which this practice has been followed for a number of years.

Most hospital wards are ill-adapted for strict quarantine and unless the quarantine is absolute, the situation becomes worse than no quarantine at all, because of a false security resulting from this action. It is oftentimes a good practice to prohibit visitation to such an exposed area for from seven to ten days, and to stop admissions to this ward for a similar period.

It is a good policy to investigate the record of each patient, in order to learn whether he or she has had this disease in infancy.

It is, of course, the superintendent's duty strictly to enforce public health regulations which have been promulgated by local boards of health.

To handle this situation in the manner suggested above appears to be practicable and safe.

Are Married Men and Women Good Interns?

It is to be supposed that the person who asks this question of THE MODERN HOSPITAL has had some difficulty with the divided allegiance of an intern who has taken upon himself both hospital and family obligations. (Since women interns are being more or less generally accepted by hospitals all over the country, this problem can be said to apply to both sexes.)

The answer cannot be expressed in any definite way without considering the individual or individuals being discussed. It can be said, however, that the duties of the hospital intern are so exacting and so time-consuming that he must be ready and willing at all times to give to the hospital unstintingly of his time and effort.

Without any attempt at being facetious, it may be stated that some administrators have noticed that the married

man, who has recently become a benedict, is less likely to be willing to devote his whole time to the hospital than one whose marital bliss has been of longer duration. Indeed, some recently married interns feel that an exception to the rule requiring their presence in the hospital during most of the day and night, should be made in their cases.

It should be definitely understood by all those persons accepting an internship that their service to the hospital comprises their first obligation; and that, while the hospital and its superintendent are, of course, interested in the happiness and welfare of all those persons working in the institution, yet no exception to its regulations can be consistently made because the intern is married.

In one institution a married intern was rather regularly stinting the time spent in the hospital; asking other interns to perform his work, and not being fully honest in regard to signing in and out. When he was discovered by the superintendent carrying out this practice, his only excuse was that he was required to spend more time at home than the hospital schedule allowed. This institution, instead of discharging the intern as might be expected, required him to stay in the hospital every night for two weeks.

It is because of the frequent occurrence of just such trouble that many hospitals refuse to accept married interns. In others, when it is learned that the applicant for internship is not single, a special contract is prepared, in which complete allegiance to the hospital's welfare is stressed.

Interns who marry nurses during their service in the hospital are particularly troublesome, because not only do they often lessen their own efficiency but also the usefulness of another of the hospital's personnel.

To meet this situation, superintendents often rule that it is not permissible for both a physician and his wife to be attached to the hospital at any one time. It appears that this ruling is just, and that the efficiency of the hospital will be forwarded by its observation.

If Erysipelas Develops in a Surgical Ward, What Measures Should Be Taken?

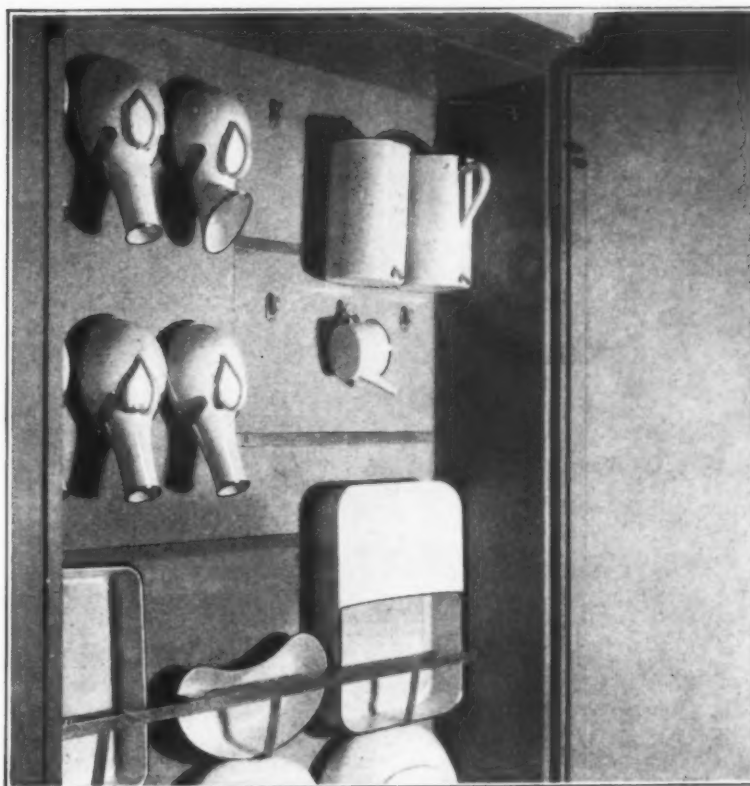
Today, erysipelas is not the scourge of the surgical department that it once was, although many institutions have great fear of its development in their wards. We have learned that this disease is not transmitted through the air but by unclean hands, instruments and utensils or by soiled gowns and bed linen. It is perfectly possible, although not always practicable or often necessary, for a case of erysipelas to be safely treated in the same ward with other patients without endangering in any serious degree their welfare.

If a patient develops this infection of the face in a surgical ward, it is, of course, most advisable immediately to remove him to other surroundings.

The isolation of erysipelas nowadays is similar in detail to that employed in the case of pneumonia or typhoid fever. These are infectious and not contagious conditions, implying, of course, that in the former transmission of the disease is more difficult and less frequent than in the latter.

The bed linen of this patient should be sterilized in a steam sterilizer. If such equipment is not at hand, the sheets, pillowcases and blankets may be immersed in a disinfectant solution (such as one of 10 per cent formalin), and the mattress sterilized by fumigation with formaldehyde gas. The bed should be cleansed with soap and water. Such simple precautions are usually all that are necessary in protecting others from developing this disease.

In this cabinet in a well known Chicago hospital are shown eight different Vollrath items: male urinals, female urinal, irrigators, hospital cup, instrument tray, puspan, douche pan and bed pans. Note the sensible designs of these items and the absence of corners, rivets and seams. All Vollrath vessels have three coats of enamel and are as easy to clean as china.



There is a Vollrath vessel for every hospital need

NO OTHER line of enameled ware is so complete in hospital items as Vollrath Ware. Those shown here are but representative of the line. There is a Vollrath vessel for every hospital need.

Hospitals have found that because the base of Vollrath Ware is made of heavier gauge steel, it is more resistant to blows. It lasts longer and is less expensive in the long run.

Every item of Vollrath Hospital Ware has *three* coats of vitreous porcelain enamel. Each coat is *fused on* at a temperature of 1700 degrees Fahrenheit. The base is sheet iron of the proper tensile strength and ductility to make substantial ware.

A highly glazed surface makes these vessels as easy to clean as

china. Suds and hot water are sufficient for most work; in extreme cases a mild detergent powder can be used. Never use an abrasive cleansing agent.

Because the surfaces are non-porous, they are slow to stain. No corners, rivets or seams provide lodging places for dirt or germs.

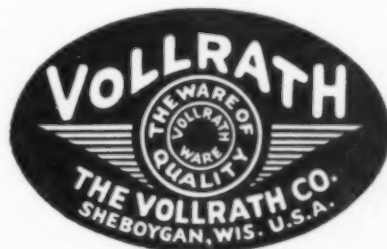
Vollrath Ware stands up in-

definitely under repeated sterilizing because the enamel is not affected by heat, or steam pressure.

Handles, spouts, ears and other attachments are gas-welded in place, making them integral with the body of the vessel. They cannot come off, break loose or crack and there are no rivets to work loose.

The snowy-white surfaces of Vollrath vessels add greatly to the sanitary appearance of the hospital. Patients are so apt to judge a hospital by its bed pans, irrigators, jars and those things with which they come into daily contact.

Your regular supply houses will give you full details about Vollrath Hospital Ware or write us for our complete catalog.



THE VOLLRATH COMPANY

Established 1874

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LONDON UNIVERSITY COLLEGE HOSPITAL ADDS OBSTETRICAL UNIT

By George Blacker, Dean, University College Hospital Medical School, University of London,
London, England

A NEW obstetric hospital and residents' quarters have been built as an adjunct to the University College Hospital, London, with part of a benefaction granted by the Rockefeller trustees.

The new building is situated in Huntley street, with frontages to University street and Pancras street, and is connected with the main building by a tunnel, which gives access also to the new ear hospital now being built, and to the nurses' home. There is a short frontage on the west side of Mortimer Market by which access is obtained to the hospital by tradesmen, and where a graduated slope of easy gradient is provided for the use of stretcher cases.

The basement floor of the new hospital in its northern portion contains the kitchen department for the obstetric hospital and for the new ear hospital. A large service room adjoins the kitchen, with the food lift opening into it, and the necessary milk, grocery and storerooms, and the coal stores are in the vaults under the footpath.

The walls are lined throughout with non-crazing tiles, and the floors are laid with special red tiles. The basement is well lighted from the adjoining yards and areas, and is adequately ventilated by a system of ducts connected with upcast shafts, having electrically driven fans in special chambers at the top of the buildings.

The southern portion of the basement contains the out-patient department, consisting of a waiting hall, sister's office, porters' room and small dispensary. Opening off these are two consultation rooms for members of the staff, adequate dressing rooms and lavatory accommodation for the patients, and a large well lighted examination room with a small clinical laboratory, and a case book room adjoining. Adequate lavatory basins and slop sinks are provided for the use of staff, nurses and students. The entrance to this department is reached directly from Huntley street by a separate patients' stairway, and also by the graduated slope from Mortimer Market.

The central portion of the basement is occupied by the

admission department for maternity cases. This consists of a waiting room, examination room and a separate bath-room fitted with a special douche bath. All maternity cases are seen in this department, examined and drafted either to a labor ward or to a waiting ward, as may be necessary.

Before admission patients are bathed and clothed in hospital clothing, their own clothes being sent home. In the immediate proximity of the examination room is the lift by which access is obtained to all the floors of the hospital.

The main entrance to the ground floor is in the middle of the Huntley street façade. This comprises a small entrance hall especially designed and decorated as a memorial to the ladies committee which raised the endowment fund for the hospital. It has marble walls and a domed and decorated ceiling, and the names of the members of the committee are engraved upon one of the walls. Adjoining this is the porters' office and a waiting room for patients' friends.

Immediately opposite is the main staircase, adequately lighted by large windows on every landing.

The north end of the ground floor contains the director's private room and a room for his secretary, the sitting room of the sister-in-charge and rooms for midwives, welfare visitors and students; also a staff room for the honorary members of the staff.

At the south end of the ground floor is a ward for gynecological patients, containing ten beds. This ward, as are all the wards of the hospital, is provided with a bathroom, utility room, small clinical laboratory and linen room, and in the sanitary block opening out of the ward is the necessary sanitary accommodation for the patients.

The walls of the wards are painted with enamel paint, as are also the ceilings, and they are heated by the panel system of heating, the panels being contained in the ceiling. This system has obviously definite advantages.

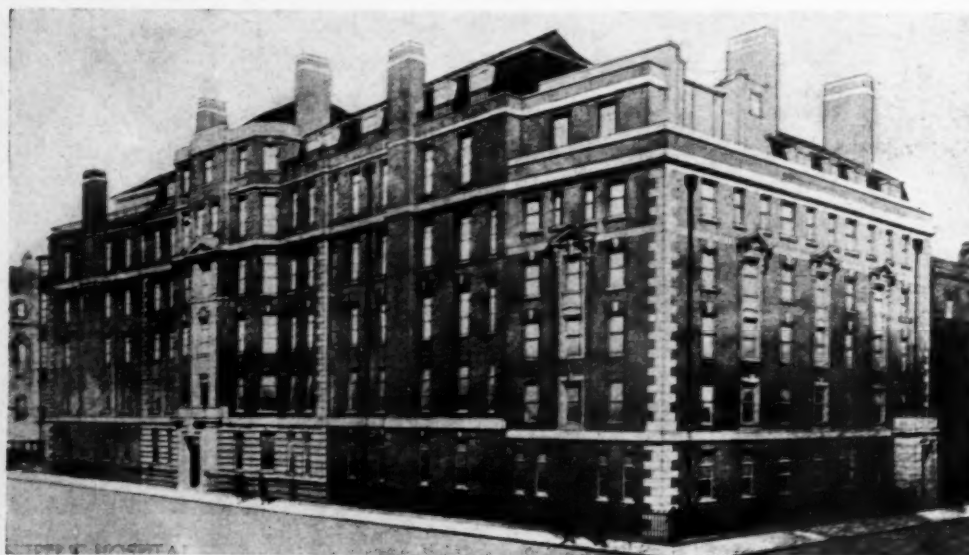
The ward has indirect lighting by electric lights in the center and over each patient's bed is a separate light, with a plug for a hand lamp.

All wards are wired for radio, and a head phone is provided for each patient.

The floor covering is linoleum, cemented down on to a cement floor and filleted at its rounded junction with the walls.

Each ward contains a central double ward fire, with flues running under the floor for further heating purposes.

The first floor provides two wards—a gynecological ward with ten beds and an obstetric ward with six



Obstetric hospital and residents' quarters of the University College Hospital

Greatly Increased Efficiency In Hospital Service

What genuine satisfaction comes to the Hospital Superintendent who uses Schoedinger's Visible Clinical System of Chart Filing and finds everyone pleased with it.

Every Hospital Superintendent is endeavoring to make the Hospital service more efficient. Many have accomplished this by using the Schoedinger System of chart filing, which is daily growing in popularity.

This System is exceedingly simple as will be shown in the illustration.

The Special Noiseless Aluminum Chart Holders are hung one behind the other and the one in the rear just enough higher than the one in front to see the physician's name, the patient's name and room number at the top.

The Nurse sees all these name plates at the top at a glance and selects the right chart holder without delay or mistake.

Write today for prices



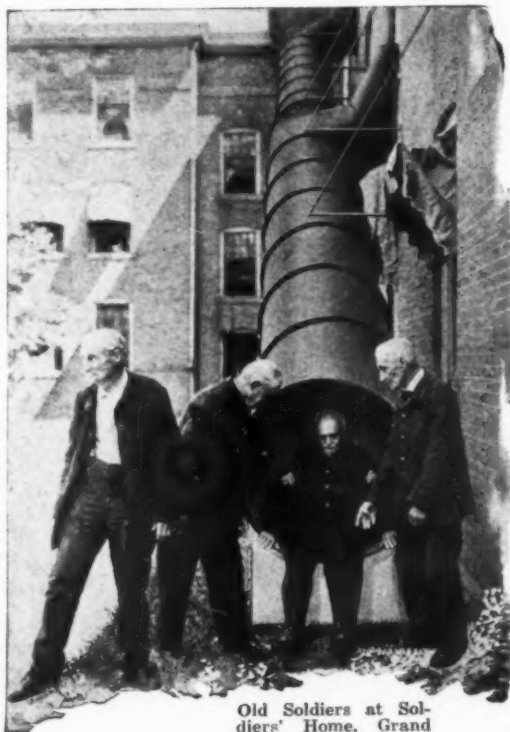
Visible Clinical Record Chart Desk C.A.6

32 in. high, 37 in. wide, 19½ in. deep

To Hold Thirty Special Noiseless Aluminum Book Form Chart Holders

Rack size 29¾ in. wide over all; 10 in. deep

F. O. SCHOEDINGER *Manufacturer* Columbus, Ohio



Old Soldiers at Soldiers' Home, Grand Rapids, Mich., showing how it works.

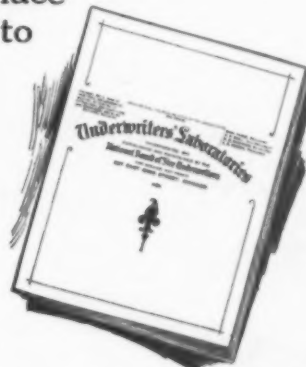
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or too Sick to Make a Safe Exit in a

POTTER TUBULAR SLIDE

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When the fire gong sounds, it is up to the attendants to get the patients out. The difference between carrying them to a safe place and slipping them to safety through a Potter Tubular Slide is the difference between great loss of life and the escape of everyone without an injury.



This book tells the rigid tests that influence the seal of approval of the Underwriters Laboratories. Ask for it.

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1866 Conway Bldg. CHICAGO

beds, designed on similar lines. In the central part of this floor is a nursery with special babies' baths and the necessary shelving accommodation for their baskets and washing appliances. Adjoining this is a nursery anteroom, provided with sterilizers and the necessary washing sinks for the use of the nurses. There is also on this floor a labor ward. Each labor ward has attached to it an annex, containing lavatory basins and slop sinks for washing-up purposes, and fitted with shelving for the accommodation of lotion jars and other necessities. The actual ward, for ease of sterilization, contains the labor bed only and has no fixed fittings. Three such labor wards and annexes are provided in the hospital and each obstetric ward has attached to it its own nursery and its own anteroom.

The total accommodation comprises three gynecological wards, containing ten beds each, and five obstetric wards with six beds in each. Each of these latter wards is, however, large enough to contain eight beds.

Each obstetric ward has attached to it a balcony facing south, large enough to accommodate the patients' beds, and suitably shielded from the weather.

On each floor is a service room which is used as a ward kitchen for the wards on the floor. The food lift opens into it, and off it is a larder.

The second and third floors are a repetition of the first.

The fourth floor contains an obstetric ward at its south end, and its northern half is given up to the main operating theater flat. The theater has an adjacent annex for washing-up, and there are sterilizing, anesthetic and recovery rooms opening into the theater, and the necessary accommodation for nurses, dressers and surgeons. Comprised in the flat is a spare recovery room, sterilizing room for large dressings sterilizer, instrument room, nurses' anteroom, dressers' room and bathroom with a shower bath and lavatory. The theater has two galleries for students' use—one on the floor level immediately below the north window of the theater, and the other on a higher level, with a plate glass front cutting it off from the main theater. Entrance to these galleries is obtained from the fifth floor. The floors of the theater flat have marble terrazzo paving throughout and the walls of the theater and its annexes, up to a height of eight feet, are surfaced with a light green Biancola marble finish, and above this with enamel paint.

Artificial lighting is provided by a shadowless lamp suspended from the center of the ceiling by flush ceiling lights for general purposes and by two projection lamps mounted at either end of the students' gallery on a ball and socket joint for illumination in the lithotomy position.

The basins and sinks in the washing-up annex are fitted with elbow taps. In the theater sterilizing room is a sterilizer for bowls, and sterilizers for hot and cold water and for saline solution. The outlet pipes of these latter



A view of the operating theater showing the entrance to the students' gallery

penetrate the theater wall, and are operated from within the theater by foot pedals.

The two instrument sterilizers are placed in the sterilizing room at the level of a large hatch through which access is obtained to them, their covers being operated by a foot pedal placed within the theater. Ventilation is so arranged that the steam from the sterilizing room is drawn out through the roof and does not escape into the theater as a whole. The main dressing sterilizer is contained in a separate room and all the sterilizers are heated by steam from the main boilers.

A soiled linen chute has been installed, constructed of glazed stoneware and properly ventilated. It has branches on each floor level, opening into the nurses' sanitary block, and a flushing arrangement apparatus from above the top floor. The lower end discharges into a soiled linen room situated in the basement, which communicates directly with the area.

The fifth floor at its north end provides a small clinical lecture theater, clinical laboratories and case book room. It also contains four small observation or septic wards, with the requisite service room and larder, bath, linen and utility rooms. The south end of this floor is devoted to a large solarium, both covered and open. The solarium is tiled, and the ceiling has a blue finish. The whole of the windows are arranged to open the full height and width of their respective openings.

Above the fifth floor, within the fireproof roof space, are the tank rooms and fan chambers. Tank rooms are also provided on the top floor of each sanitary tower.

The basement of the resident medical officers and students' quarters has a complete kitchen department for the service of the building, with a large service room, intervening between it and the dining room, for residents and students. Also on this floor are linen stores, bicycle stores and lavatories.

The ground floor provides a large common room for the residents, and a smaller one for students on duty in the maternity department, both panelled in oak to a height

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The Pathway to health

Your hospital is the pathway to health for hundreds, perhaps thousands of people.

Make it quiet and restful and your patients will speed so much the faster along the road to recovery.

Any hospital, new or old, may be quieted by the Johns-Manville method of acoustical treatment, which localizes and ab-

sorbs the inevitable noises of hospital activity.

This treatment subdues reverberation, echo, and resonance. It brings a restfulness that conserves the nervous energy of both your patients and personnel.



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JOHNS-MANVILLE

Acoustical Treatment

of seven feet six inches. At the northeast angle of the building there is a suite of sitting room, bedroom and bathroom, for the use either of the director or his first assistant, who, it is intended, shall reside on the premises. This flat is also provided with separate cloak and laboratory accommodation nearby.

The main entrance is by a porch at the end of the building nearest Tottenham Court Road, a staircase also being at that end.

The students' house provides twenty sitting rooms and bedrooms for resident officers, and sixteen bed sitting rooms for students, together with a sufficiency of bathrooms, lavatories and box rooms.

The buildings are throughout of hard London stock bricks in cement mortar, with Staffordshire blue bricks for the more heavily loaded piers. The walls are faced with Bracknell red bricks. Brown Portland stone is used for the entrance porches and, sparingly, elsewhere.

The roofs are of steel and concrete construction and are covered with green slates.

The floors of the hospital buildings are of fireproof construction. The doors are either teak or mahogany. Vitreous china taps are used throughout and the door fittings, including the various protective plates are of a special homogeneous white metal, which is readily cleansed.

HOW THE PHYSIOTHERAPY DEPARTMENT FUNCTIONS IN A GENERAL HOSPITAL

In view of the steadily growing interest in the field of physiotherapy, the following list of the agents used in its application, as noted by Dr. Spencer T. Snedecor, director of physiotherapy department, Hackensack Hospital, Hackensack, N. J., in a recent issue of the *Journal of the Medical Society of New Jersey*, is of interest:

The Agents in Physiotherapy

I Heat.

(1) Conductive heat.

Hot water bottle, electric pad, hot bath, hot compresses.

(2) Convective Heat—Radiant Heat.

- (a) Carbon filament lamps.
- (b) Bakers.
- (c) Cabinets.
- (d) Deep therapy lamps.
- (e) Infra-red lamps.

(3) Convulsive Heat—Diathermy.

High frequency electric currents.

A Medical—Forms of application-circuits.

- (a) D'Arsonval.
- (b) Oudin.
- (c) Tesla.
- (d) Autocondensation.

B Surgical.

- (a) Electrodesiccation.
- (b) Electrocoagulation.
- (c) Endothermy, radio knife, etc.

II Ultraviolet Light.

- (1) Carbon arc lamps.
- (2) Quartz mercury vapor arc lamps.
 - (a) Air cooled.
 - (b) Water cooled.

III Other Electrical Currents.

- (1) High voltage.
 - (a) Static electricity.
- (2) Low voltage.
 - (a) Faradism.
 - (b) Galvanism.
 - (c) Sinusoidal currents.

IV X-Rays.

V Hydrotherapy.

(1) External.

- A Hot baths.
 - (a) Body baths.
 - (b) Sitz baths.
- B Whirlpool baths.
- C Douche spray.

(2) Internal.

- (A) Colonic irrigation.
- (B) Vaginal douche.
- (C) Gastric lavage.

VI Mechanotherapy.

(1) Massage.

(2) Vibration.

- (a) Hand.
- (b) Mechanical.

(3) Exercises.

- (a) Active.
- (b) Passive.

Nearly all these agents are used in the Hackensack Hospital with varying degrees of frequency and usefulness. They are applied only on prescription of the visiting physicians and surgeons and to those cases in which therapeutic results may be reasonably expected.

During the past year 6432 patients have received 12,457 treatments, from which it will be noticed that each patient averages two different treatments on each visit. The physiotherapy staff consists of a trained technician, two student nurses and an orderly. Every patient is examined before the first treatment and the exact prescription is outlined for the technician to follow. All treatments are supervised and the progress from time to time is noted.

This apparatus is listed as follows: two heat lamps, three bakers, three infra-red lamps (one very large) one air cooled quartz lamp, one water cooled quartz lamp, one carbon arc lamp, one large high frequency machine, one portable high frequency machine, one Morse wave generator, one Bristow coil, one whirlpool bath, one static machine.

The foregoing list is suitable for a similar department in any general hospital, or for a doctor who wishes to go into physiotherapy extensively.

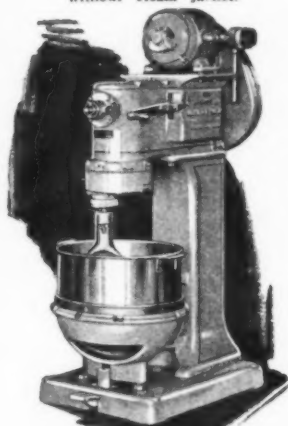
VILLARD-DE-LANS (ISERE) HAS WINTER STATION FOR CHILDREN AND CONVALESCENTS

On November 14, 1926, in the village of Villard-de-Lans, France, there was opened a station especially designed for the winter care of anemic and otherwise debilitated children. This is the first of its kind in France and is unique in that children with contagious diseases, especially pulmonary tuberculosis, are excluded. The same rule applies to every person who wishes to enter the town. The institution, which is well equipped with physiotherapy and gymnastic apparatus, is protected by a belt of mountains. Provision is made for winter sports and actinotherapy.

The occupational therapist, with her knowledge of crafts, and the training that has especially fitted her to study each case with sympathetic understanding and then, with patience, teach crafts with reference to individual needs, has, in marked degree, those qualifications that, combined with general education and teaching experience are essential in teaching the blind.

GIANT 4-SPEED
HEAVY DUTY
MIXER

May be had with or
without steam jacket.



Giant Mixers—Four Sizes

A Giant equipped kitchen sets a new standard of efficient operation. Where hand work costs you dollars—a Giant costs only pennies. Where hand work requires hours—a Giant needs only minutes. Where hand work is wasteful of perfectly good materials—a Giant saves every shred. Where hand work is unsanitary—a Giant is always the perfection of cleanliness.

One Giant does more work than ten skilled hands—does it hour after hour—changes from one job to another with utmost simplicity and ease—when operating it needs little supervision, releasing the attendant for other necessary duties. One large cake bakery uses over 70 Giant Mixers.

An investment in a Giant mechanical helper brings rich dividends in labor and time saved, in faster and better production with more ease and satisfaction.

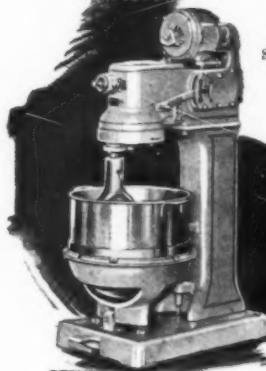
Write for bulletin giving full description of the size Giant which best fits your needs.

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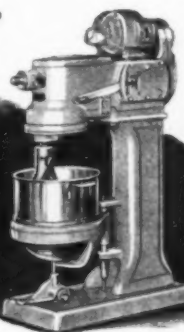
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Croquettes
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Custard
Dessert sauces
Fish cakes
Dumplings
Fruit juices, jellies and jams
Fritters
Gravy stock
Griddle cakes
Grinding coffee and spices
Grinding meats
Hash
Heavy sauces and creams
Ice cream
Jellied meats and poultry
Mashed Potatoes
Mash turnip, squash, pumpkin
Mayonnaise and dressings
Meat loafs
Mustard
Peanut butter and nut pastes
Pie fillers
Puddings
Purees
Rubbing up cheese
Salads
Sausage and hamburger
Slicing fruits
Slicing vegetables
Stuffing for vegetables and fruit
Soup stock
Straining soups
Sweet potato pies or puddings
Waffles
Whipped cream
Omelets



This type of food truck is being used
with excellent results in the Wilkes
Barre City Hospital.

Elmer E. Matthews, Supt.

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HOSPITAL PANTRY ELECTRIC TRUCK

Table made of heavy tinned copper with polished Nickel Top.

Closet constructed of galvanized metal with reinforced bands.

Sliding Doors.

4 Nickel Jars suitable for soups or vegetables.

1 Polished Nickel Meat Dish with Rolling Cover.

Table and Closet both heated electrically.

Maximum Current Consumption, 3000 watts.

*We manufacture a complete line of French
Ranges, Kitchen Equipment and Utensils and
are in a position to give your requirements
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LAUNDERING FOR CONVALESCENTS— A DIFFERENT PROBLEM

By Lillian A. Kelm, formerly Directress, The Burke Foundation,
White Plains, N. Y.

STANDARDS of laundry equipment and procedure, so well worked out for the general hospital and the commercial plant, apply only in part to the convalescent institution for which standards of spacing and management have not yet been developed.

Convalescent hospitals and rest homes vary in size from those of a few beds to those with several hundred; the reception ages range from infancy to senility and, in this country, include practically all social grades and races. A working division for the purposes of this report, however, would be for adult as against child care. Children ranging from ten to sixteen years are mainly in the so-called children's institutions, but may be, and are, adapted, with some separation and specialized regime, to the adult institutions.

Adults Take Care of Their Own Laundry

Adult convalescent patients wear the clothing they bring with them, consisting generally of one change with a few toilet articles and accessories, and do some washing and ironing for themselves or have their laundry done at their own expense at some nearby commercial plant. During more extended residence some of them send their clothing home to be laundered.

The institution has its own store from which it sells or gives articles of clothing and in certain needy cases aids by sending the patient's things to the house laundry. In one large home all washing is done by the house and the cost prorated among the patients, while the ironing is done by the patients themselves in assigned hours and places.

The advanced and active patients frequently aid the weaker ones in this detail and the employees at all times help the severely handicapped. Often a small fund for this work is made applicable to those who cannot manage to do their own ironing.

Articles that are vermin infested or have been used by contagious suspects are removed and sterilized by the home. A varying degree of inspection of all outfits, upon arrival, is practiced and in some institutions all effects are placed in sanitary boxes, and private luggage is cleaned and held until time of discharge.

The method employed in practically all of the children's and many of the adolescents' homes is to store the patient's clothing, without laundering, and substitute more or less standardized outfits which the institution provides and keeps in order, free of cost, either in its own or in a commercial laundry. A small charge, such as fifty cents a week, is made in certain institutions and the procedure is modified in accordance with local conditions.

The main convalescent hospital of the Burke Foundation, with a capacity of nearly 300 patients (one-tenth being adolescents) and 100 employees, has a detached two-story, modernly equipped laundry building with connecting subway and covered corridors. This building also houses many of the women employees. The personnel is made up of two women and two men assistants. The hours are from 7 a. m. to 4 p. m., with Saturday afternoon and Sunday off.

The work includes all bed and general house linen,

blankets, personal laundry for the staff, and the customary stated number of pieces for the employees. Occasional service to needy patients is of minor importance. Repairs are made by the engineer's department. A mattress sterilizer finds comparatively infrequent but valuable usage. Only soap chips, soda, bluing and starch are used in the laundry processes.

Daily collections of soiled clothing, check-up with accompanying lists, weekly sorting of pieces for repair, a central linen closet, monthly inventory and a standardized apportionment for each cottage, section, department or house obtain as the usual procedure of good management. The linen loss through the use of 6,300 patients, theft and otherwise, totaled less than ninety pieces in one year.

Somewhat unique is the repair of all linens by women patients, as a part of their occupational therapy prescription. One hour daily is given to this work and most of the repairing is accomplished in one or two days each week. Over 6,000 pieces were repaired by the women patients last year. All of this work is, of course, under the supervision of the director of occupational therapy with patient aids. As a result no seamstress department has ever been necessary at the institution and a great saving has thereby been effected.

Statement of Laundry Costs for Year

Output—500,000 pieces (4/9 being starched), plus 2,000 blankets.	
Salaries	\$2,900
Supplies	800
Work and material from engineer's department....	400

Total running cost, not including overhead.....\$4,100

The total cost approximates \$10 per bed per year.

Each cottage unit, consisting of from forty to fifty patients, has provided a special wash sink and electric irons. Drying is done mainly on outdoor lines near exits and on sunny porches, but indoor frames, placed unobtrusively, are available as weather and season demand.

Such comparatively low running costs are largely brought about by a skilled head laundress and the cooperation of the engineers. There is, of course, comparatively much less daily wear on the linen in convalescent homes. These factors all combine to make the lower per capita costs of convalescent as compared with general hospital laundry.

HOW THE MOTION PICTURE WAS USED FOR PUBLICITY

How the motion picture may be used in hospital publicity is well illustrated in the recent Mount Sinai Hospital week in Hartford, Conn. The campaign week opened with the showing of the film, "Let's Make a Visit to Mount Sinai Hospital," which was exhibited during the week at the various motion picture theaters of the city. The campaign was also mentioned at the church services of all denominations the Sunday preceding the start of the campaign.



KARO is the Corn Syrup now being prescribed for Infant Feeding—not only because of its high Dextrose and Dextrin content—but because parents can secure Karo from grocers in every village, town and city in every state of the U. S. A.



FOR CONVENIENCE THE SMALLER
OR 1½ LB. CAN IS RECOMMENDED

For Infant Feeding

KARO should be adjusted in accordance with the calorific value of this food—these values will be furnished to physicians on request. Write Corn Products Refining Company, 17 Battery Place, New York City.

NURSING AND THE HOSPITAL

Conducted by M. HELENA MC MILLAN, R. N.,
Director, School of Nursing, Presbyterian Hospital, Chicago

SHOULD THE SMALL HOSPITAL EMPLOY GRADUATE OR STUDENT NURSES?

By R. D. Brisbane, Superintendent, San Jose Hospital
San Jose, Calif.

IN THE minds of many hospital executives and trustees, especially of the smaller institutions, the idea still holds that one of the best ways to cut expenses is to establish a training school for nurses.

This may be true in some localities, but where the student is given proper living conditions, an eight-hour day of labor and competent instruction, we have found that the monetary returns are all "Irish dividends."

Those who direct commercial enterprises of great magnitude have learned rapidly during the last decade that the net growth of their respective endeavors is in direct proportion to the spirit of humanity, may we say the spirit of Christianity, with which they approach their trade and their employees.

The hospital idea was born in humble devotion to the needs of the unfortunate. It is important, therefore, that the spirit of sacrifice and the Golden Rule be the guiding star of the rapidly multiplying hospitals and all their attending ramifications.

And in a school of nursing where young women are being fitted for an important and noble profession, one that calls for high ethical standards as well as exceptional technical training, it is important that the members of the board of trustees ask themselves, "How may we exert the most enduring influence for good and give the best education to the young women under our care?" and not, "How can we get more work from the students to save expense?"

The hospital or the training school established for the dividends that may be returned in dollars or cents is doomed to failure, perhaps not in one year or in five years but sooner or later, for greed will slowly destroy the spirit as well as the body of every department, and the place as a whole.

When this question came up for discussion in our hospital there fortunately were men on the board of directors and on the medical advisory board who decided for a training school because of what it might mean to the community.

The books, which have been kept as accurately as possible during the first three years of operation, prove conclusively that a training school is a financial loss. Costs will vary somewhat in different localities but the figures presented here may help someone else to solve the problem in the best way.

Our nurses' home is composed of fifty private rooms, parlors, recreation room, classrooms, a suite for the superintendent of nurses and another for the instructor. A piano was given to the nurses by the hospital two years ago and this year the physicians of the staff and the hospital presented them with a large radio. Other recreational facilities will be added as soon as possible.

Cost of Student Nurses Based on Average Expense Over Period of Three Years, Cost by Month

Fixed Charges			
Depreciation on N. H. Bldg., 2 % on \$47,429.64	118.55		
Depreciation on F. and Fixt., 6 2-3% 8,943.57	50.05		
Cost of land	3,000.00		
7% on total investment of.....\$59,373.21	346.34		
Insurance on Bldg. and F. and F.....	21.00		
Taxes and Admin., overhead per month	100.00	635.94	
Monthly Expenses			
Heat	\$ 206.39		
Water	33.15		
Electricity	13.40		
Gas for kitchenette80		
Maid, \$65 per month, board and laundry.....	100.00		
House mother, evenings only	25.00		
Instructor, \$125 per month, room, board, laundry	185.00		
Lecture courses and library fund	20.00	583.74	
Students' Personal Expenses			
Cash remuneration, average for 24 months, for 50 students, per month	600.00		
Board, 80 meals per month at 40c per meal....	1,600.00		
Personal laundry, \$5.00 per month	250.00		
Bed linen, 15c per week	32.50		
Free medical service	68.85		
Graduation and entertainment expense	50.00	2,601.35	
Total expense for fifty students per month		3,821.03	

In explanation of the above table the following should be noted:

Figures under fixed charges are based on depreciation for the year divided by twelve for the monthly basis.

"Heat" shows the proportionate depreciation on the boiler house and equipment as well as labor of engineers and fuel.

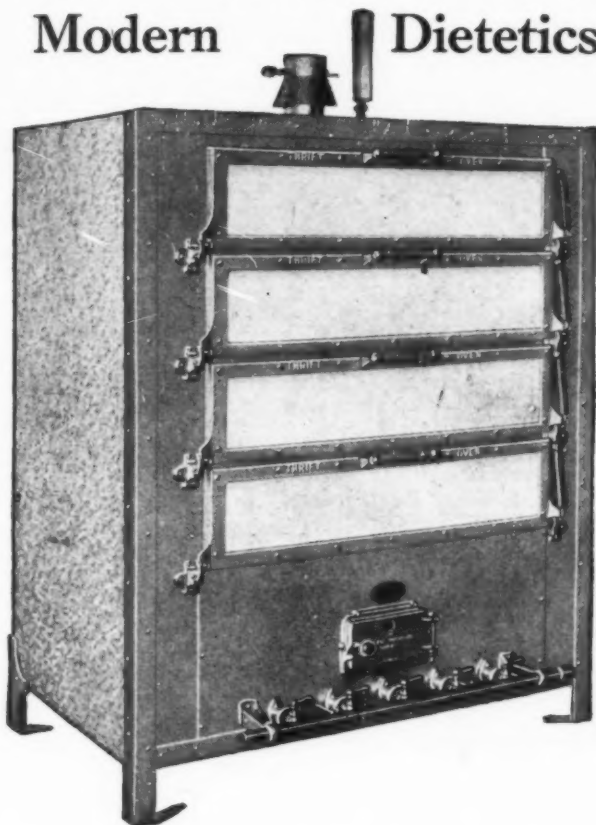
Board of students includes all overhead on each meal cost, as well as cost of raw food.

Students are cared for in illness free of charge, if the illness was not due to some difficulty that arose previous to entry as a student.

In California the student is on probation for four months, with a four-hour day. The remainder of the time she has an eight-hour day.

As the graduates work ten hours a day, it would be

Suited to the Needs of Modern Dietetics



The THRIFT Oven

KEEPING pace with the needs of modern dietetics, the Thrift Oven construction permits more uniform quality of baked foods at lower cost.

The Siphon Flue—a unique Thrift Oven feature brings about uniform distribution and more complete utilization of heat insuring improved baking on each deck.

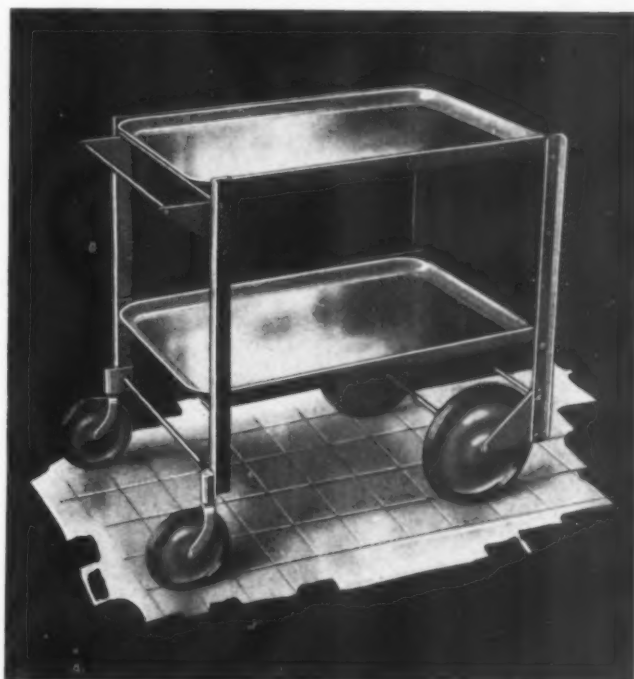
Once brought up to desired baking temperature, the Thrift Oven bakes with "retained heat." This means minimum gas consumption.

It is ideally suited to the needs of the diet kitchen as to performance, cleanliness and neat appearance.

Send for Bulletin M. H. 125 explaining the value of the Thrift Oven in the Diet Kitchen

The Surface Combustion Co.
366 GERARD AVENUE, NEW YORK, N.Y.
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The Faultless



SERVICE WAGON

Every hospital will find these sturdy, silent, Service-Wagons invaluable for general use in and out of the wards, operating room, kitchen, or laundry. The easily cleaned, all steel construction assures a long life of efficient service. Built in two-three-four and five shelf sizes, they will perform duties now required of several nurses. For carrying meals to the wards or private rooms, the four or five shelf Wagon will save many trips while the two or three shelf size makes an ideal instrument table for the operating room or a most sanitary dressing table. These Wagons when equipped with metal dish boxes will carry a greater load of soiled dishes back to the kitchen. The trays and dish boxes are twenty inches wide by thirty inches long and will slide in or out from either end. FAULTLESS Wagons are finished in white or gray enamel and are equipped with roller bearing, disc wheels having large, cushion rubber tires. Sold direct or through jobbers.

WRITE FOR FULL
DESCRIPTION

Bloomfield Mfg. Co.
BLOOMFIELD, INDIANA



necessary to have forty graduate nurses to replace fifty students. Paying the graduate \$90 per month and maintenance, we have found that students costs us from \$300 to \$500 per month more than the necessary graduate staff would cost.

Why continue? In the first place because our board of directors and the medical advisory board feel that San Jose Hospital fulfills a duty to the community of San Jose and the surrounding territory by maintaining a properly conducted school for the training of its young women.

Secondly, every young woman who comes to the hospital for training automatically interests her family and relatives in the activities of the institution, and she also becomes a medium of expression and explanation of the hospital to the public, which is still grossly uninformed regarding hospitals and their functions. If the impression disseminated is a good one, a certain proportion of these persons will sometime become patrons of the hospital.

Again, by training its own nurses, the hospital is in time able to staff the institution with supervisors and special duty nurses molded to its own traditions and technique, thus giving better service to patients, with less internal friction.

Better Morale Is Fostered

In the fourth place, we have found that the better morale and discipline and the cheery atmosphere created by younger women, react for the good of patients and for happier relationship between the nurses and the physicians and other personnel throughout the hospital. Youth is enthusiastic, hopeful, not given to holding grudges, and its troubles are easily forgotten.

It may be said that these are material advantages that outweigh the difference in costs. This may be true, but the fact must not be overlooked that those in favor of a training school cast their vote because of the benefit accruing to the community and not because of the saving in expense to the hospital.

Everything lies in the viewpoint. We still lose money on students, but we are making friends. We have many hard problems to meet with fifty healthy, red blooded young people under our guidance, but we look into the future and see the possibilities that are before them and the educational center that is being established, and we count any reasonable sacrifice worth while if thereby even one in ten of these young women may make the world the better for her ministry.

If a school is established with the aim of doing all that is possible for the students who enter it and for the homes from which they come, we believe there is little doubt of success. Financially it may be a loss; it is for the directors or trustees of each institution to decide the road they wish to follow.

NURSING CONDITIONS IN SOUTH AFRICA

In view of the ever-recurring discussion of the shortage of nurses and other nursing problems, the following from the *South African Nursing Record* is interesting and throws a light on nursing conditions in South Africa:

"At the General Hospital, Johannesburg, which has the largest school of nursing in the Union, over 800 applications were received last year for approximately 100 vacancies. Furthermore the type of applicant is now better educated than formerly, and appears to have a better idea of the duties expected of her.

"The establishment of a preparatory course under the direction of a specially trained Sister tutor has proved

an unqualified success, and it is found that the young women of South Africa fully appreciate a training which provides a thorough theoretical and practical professional education. They prove apt pupils, anxious to take advantage of all the facilities placed at their disposal.

"The South African Trained Nurses' Association strongly recommends the establishment of preparatory courses and the appointment of Sister tutors in the other three provinces, and there is evidence that the recommendation meets with approval.

"In the Transvaal, owing to the introduction of a nurses' relief ordinance in 1918, which provides for a weekly day of rest for all nurses, including pupils in training, it was found that the curriculum could not be covered satisfactorily in a period of three years, as the pupils were legally entitled to seventy-eight days off duty per annum, including thirty days annual leave. Most of the training schools in that province therefore increased the length of the course to four years. The low level of general education, which is now raised, also contributed largely to the necessity for the increase in the length of the course, as did the high standard demanded by the Transvaal Medical Council (the state examining body) for the qualifying examination on completion of training.

"This medical council established an examination in anatomy and physiology for student nurses, which is taken at about the end of the second year, and this examination must be passed before application can be made to enter for the final or qualifying examination. The fee for the junior examination is ten shillings and six pence, and for the final examination three guineas; this fee includes the registration of successful candidates.

"A nurse examiner was appointed in the Transvaal in 1916, to examine pupils in practical work. This appointment was the result of a recommendation from the South African Trained Nurses' Association. It is considered a step in the right direction, and enhances the value of the Transvaal Medical Council's certificate. Unfortunately, in spite of continuous efforts on the part of the nurses' association, the other three provinces have no nurses on their examining bodies, and it is generally felt that sufficient emphasis is not given to the examination in practical nursing."

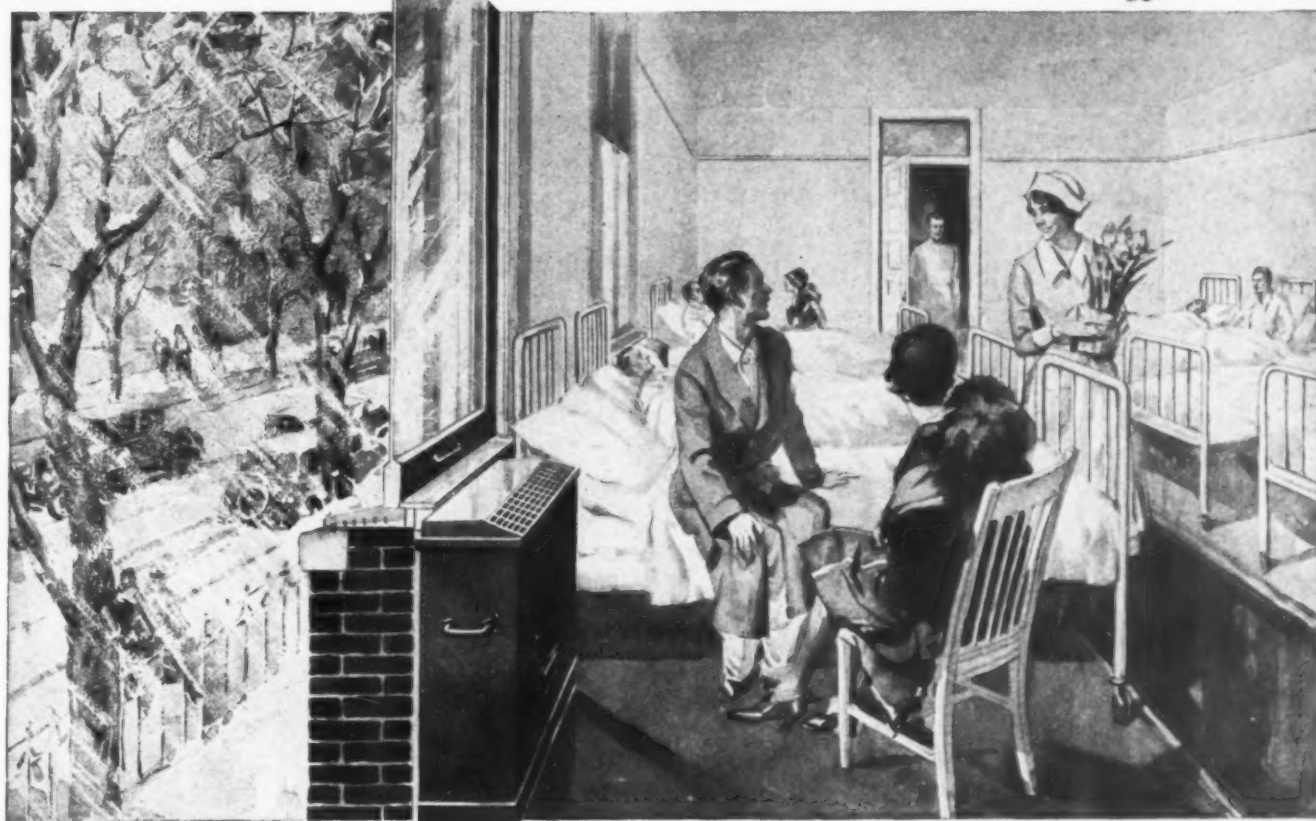
ANNUAL INSTITUTE FOR NURSES TO BE GIVEN IN AUGUST

The Illinois League of Nursing Education will conduct its fifth annual institute for nurses in Chicago during the last two weeks of August, beginning Monday, August 15, and closing Friday, August 26. A comprehensive program has been planned and will offer material of educational value to the nurse in any field of nursing.

The course is planned especially for the busy graduate nurse who cannot give the time for a longer course of study. Lectures will be given on psychology, principles of teaching, sociology and effective speaking. In addition to the lectures there will be a number of demonstrations and special lectures on nursing and health subjects. The clinical material of Chicago's large hospitals will be available to all nurses attending the institute. Excursions to the hospitals will be systematically arranged and all demonstrations in teaching, in new methods of treatment and lectures in public health subjects will be given by experts in the different fields of nursing and hospital education.

The program for this institute may be obtained from May Kennedy, Director of Institute for Nurses, 6400 Irving Park Boulevard, Chicago.

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Better record sheets—more cheerful patients—and a welcome absence of sickroom odors—all



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- C—Cone type fan specially insulated for quiet operation.

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because science has found a way to bring the stimulating outdoor air INDOORS. Much more simple than opening windows—and no dangerous drafts. Results so obviously beneficial that a Univent installation in every ward is no more than justice due patients and attendants.

Hospital authorities, architects and heating engineers endorse the Univent as the simplest, easiest controlled, most effective and economical ventilating system known.

Write for our free book "Univent Ventilation." It tells why good ventilation is necessary and shows how the Univent gives perfect ventilation regardless of extremes of weather.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES, 7 East 54th Street, New York
and MARY A. FOLEY, Director of Dietetics, Kahler Hospital, Rochester, Minn.

HOW PHOSPHATURIA IS CONTROLLED BY DIET

By George Baehr, M.D., Associate Physician, Mount Sinai Hospital,
New York

THE secretion of an alkaline urine turbid because of the presence of precipitated alkaline phosphates, has long been observed to occur in neurotic individuals and in some patients troubled with gastric hyperchlorhydria.

Few appreciate the intense discomfort that these individuals may suffer because of the greatly increased vesical irritability. Usually the bladder symptoms are out of all proportion to the gastric complaints so that the latter frequently escape observation or are not even mentioned by the patient. In extremely severe cases the bladder mucous membrane may be seen through the cystoscope to be coated with phosphatic material and at times the patient may pass slugs of phosphatic concretions.

A study of patients suffering from intense and persistent phosphaturia has convinced me of the correctness of the conception that the condition is primarily the result of a disturbance in the acid-base regulating mechanism of the body, induced by the excessive loss of hydrochloric acid in the gastric juice. Normally there is a diminution in acidity of the urine corresponding to the secretion of acid in the stomach after meals. The relationship of this postprandial alkaline tide to gastric secretion has recently been convincingly demonstrated by Hubbard and his collaborators. My patients have often shown an increase in alkalinity and in phosphaturia in samples collected two to three hours after meals.

These and other observations have indicated that phosphaturia is caused by an exaggeration of the normal urinary alkaline tide. The exaggerated postprandial alkaline tide is still further increased by the excretion of alkaline salts derived from vegetables, potatoes and most of the fruits. The normal diet provides a considerable amount of calcium and magnesium, so that much of the basic phosphates that appear in alkaline urine will be in this more easily precipitable form.

How Alkaline Tide Can Be Increased

Hubbard has shown that the alkaline tide of normal people can be increased by foods that stimulate gastric secretion. My own observations upon normal subjects as well as upon patients with clinical phosphaturia confirm these observations, but also indicate that the ingestion of foods with a predominately alkaline ash, such as vegetables, potatoes and most fruits, plays a much bigger role in exaggerating and prolonging the alkaline tide. In normal subjects with normal gastric secretion, the con-

sumption of a diet consisting solely of such vegetable matter resulted in the secretion of urine with a hydrogen ion concentration of 7.8 to 8.0. When the alkalinity of the urine reached that point, phosphaturia resulted even in the absence of any gastric hypersecretion. The subject of the experiment temporarily developed the cloudy urine and the vesical irritability ordinarily characteristic of phosphaturia.

The alkaline tide of the urine is caused by foods and by psychic factors that stimulate gastric secretion, but there is no doubt that it can be immensely exaggerated and prolonged by the consumption of base forming foods.

The administration of acids has long been employed in the treatment of this condition, on the theory that they were indicated in order to correct the urinary alkalinity. We found them to possess a limited value. The reason became obvious when we studied the influence of acids upon the urine of normal subjects. Doses of acids considerably larger than it is ordinarily practical to administer produce a definite influence upon the degree of urinary acidity, but this is so slight when compared with the effect of the base forming and acid forming elements of foods that it is almost negligible.

The correction of economic maladjustment and other psychic influence is useful but difficult to institute. The employment of atropin sulphate, of sedatives and of acids is of some limited value in helping to correct the condition and these are regularly employed in the treatment. But immediate and permanent results can be obtained with any degree of satisfaction only by additional dietetic control.

Temporarily, all base forming foods are eliminated from the diet and only acid forming or neutral foods employed. Condiments and foods that would too greatly stimulate gastric secretion are forbidden. The diet is therefore milk, cream, foods made of flour, corn starch, cereals, sugar and butter, and prunes, plums and cranberries, because of their high content in benzoic acid. Later, meat and fish in limited amounts without meat sauces, gravies or high seasonings are added. Still later, a limited amount of vegetable matter and of fruit is returned to the diet, but care is always taken that the diet contains an excess of acid forming food.

The two most stubborn cases were greatly improved by the regime, but at times they would temporarily develop phosphaturia for several hours or several days. In one man, during a period of great economic stress, even an



Architects:
Richard E. Schmidt
& Garden & Martin,
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Plumber: E. Bag-
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Don't let your Hospital get "Hardening of the Arteries"

Plumbing—the "arteries" of a hospital—means everything to its efficiency and sanitation, just as human arteries govern our span of life.

To make sure that your hospital won't get "hardening of the arteries" buy plumbing that has been proved fit for the strenuous use of hospital work.

It will pay you to find out what other hospitals are using—what plumbing they have found satisfactory.

The Oak Park Hospital, of Oak Park, Ill., has found Clow equipment entirely satisfactory.

The numberless hospitals throughout the country, which have been equipped with Clow Plumbing for years are concrete evidence that Clow is building hospital plumbing that "stays young."



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acid diet did not control him completely. Some phosphaturia and vesical irritability persisted. Upon a Sippy diet, however, of milk and cream at two hour intervals he passed a clear acid urine, always free of visible phosphates. The food could not have materially influenced the patient's acid-base regulating mechanism. The explanation was found in some experiments upon a normal subject. After twenty-four to thirty-six hours on a Sippy diet all traces of an alkaline tide disappeared and the urine showed a hydrogen ion concentration of remarkable constancy throughout the day, about 5.2. Apparently the Sippy diet results in uniform secretion of gastric juice at a constantly low rate. Hence its value in gastric ulcer and in the stubborn cases of phosphaturia.

STANDARDS SUGGESTED FOR DIETETIC DEPARTMENTS

A minimum standard for the dietetic departments of approved hospitals has been suggested to the American College of Surgeons. This standard embraces the various requirements that bring the dietetic departments up to the high standard that should be maintained in approved hospitals. The following are the requirements:

1. That there shall be a properly organized dietary department under the direction of a competent graduate dietitian whose training conforms to standards approved by the American Dietetic Association, and that this department shall be responsible for (a) the efficient administration of the general food problem; (b) the scientific dieting of patients; (c) the education of the student nurse in hospital dietetics.

2. That there shall be an adequate administrative and technical staff competent in their respective activities and conforming to proper physical, mental and character standards.

3. That the director of dietetics and staff, with the approval and cooperation of the superintendent and governing body of the hospital shall initiate and develop rules and regulations pertaining to the administrative and professional policies of the department, and that these rules and regulations specifically provide for (a) departmental and (b) interdepartmental conferences at regular intervals to review the work of the department for the purpose of improving the service and general efficiency.

4. That an adequate system of administrative, financial, clinical and technical records shall be provided.

5. That adequate administrative and teaching facilities shall be provided for the dietary department, these to include: (a) the necessary physical accommodation and equipment for dietitian's office, kitchens, storage, refrigeration and other service requirements; (b) a well equipped classroom and laboratory for the education of student nurses.

PERSONNEL MANAGEMENT DISCUSSED AT TEACHERS' COLLEGE

The conference of house directors which is an annual feature of the institution management course at Teachers' College, Columbia University, New York, was held April 28.

The subjects for discussion were personnel management and financial management. Ralph B. Spence, instructor in educational psychology, Teachers' College, presented the psychological factors that distinguish the successful employer and personnel manager. Mary Lindsley, manager, Grace Dodge Hotel, Washington, D. C., stressed the value

of close contact between employer and employee, and also the value of frequent staff meetings. She said in part: "If we pay an employee for a specified number of hours work and expect in addition to his work the interest in and loyalty to the organization that is essential for its successful operation, we must give him more than the number of dollars agreed upon for service." C. B. Stoner, general auditor, Hotels Statler, New York, also emphasized this, saying an accounting system is a good thing but personal contacts, supervision and inspection are also essential to good management. The consensus of opinion among the speakers was that feeding and housing employees is more expensive than paying them a straight salary and letting them make their own living arrangements.

Helen Henry made some pertinent remarks in regard to insurance of employees by an institution.

NEW YORK DIETITIANS HOLD MEETING

The annual lecture of the New York Association of Dietitians was given by Dr. Carl Shipley, Johns Hopkins Hospital, Baltimore, Md., on Wednesday evening, April 20, at the Horace Mann Auditorium, New York.

Dr. Shipley's subject was "Rickets," and he gave a most interesting resumé of his work on children in Baltimore, with screen illustrations showing the effect of rickets on the bone structure and tissues, and showing the marked improvement that results from giving cod liver oil and using sunlight or the violet ray.

Dr. Martha M. Elliot, director of child hygiene, Division of the Children's Bureau of Labor, Washington, D. C., and Dr. Henry P. Sherman, Columbia University, New York, discussed the lecture. Dr. Elliot told of some interesting work done on children in Porto Rico, proving that in tropical countries, unless children are deprived of sunlight, rickets is practically unknown.

About three hundred people were present.

DIETITIANS OF MINNESOTA MEET

The Minnesota Association of Hospital Dietitians held a meeting April 11, at the University Farm School, Minneapolis. A paper on "Treatment and Diet in Gastric Ulcer" was given by Dr. T. L. Tuttle, U. S. Veterans Hospital, No. 65, St. Paul, and one on "Canned Goods" by John Wilson, Minneapolis.

At a round table discussion on hospital problems the following topics were touched upon: Food service for student nurses—cafeteria service, plate service and plate or platter service; control of breakage; advantages of the central tray service in a hospital; the place of the special nurse in the diet kitchen in a private hospital. Among the speakers were dietitians from St. Luke's Hospital, St. Paul, Northern Pacific Hospital, St. Paul, Minneapolis General Hospital, Minneapolis, St. Barnabas, Minneapolis, Midway Hospital, St. Paul and Miller Hospital, St. Paul.

Students from the University of Minnesota who are specializing in dietetics and institutional management attended the meeting, as well as the dinner served to the members of the association by the Home Economics Department of the university.

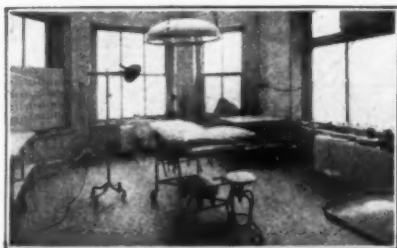
Elizabeth Beaver has completed the course of training for student dietitians at Polyclinic Hospital, New York, and accepted a position as dietitian at Woman's Hospital, New York.



Main building of the Bryn Mawr Hospital, Bryn Mawr, Pa.

LIGHTING PROTECTION

to fit your budget



Operating room of Bryn Mawr Hospital

The Exide-equipped emergency system offers positive protection against lighting interruptions — and it need not be expensive

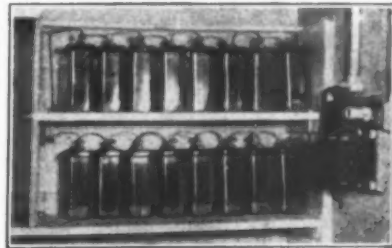


Illustration showing Exide storage battery installation

CONSIDER what sudden darkness means in a hospital—confusion, paralysis of the entire organization, the possibility that a major operation is being delayed.

In such a situation, what would you give for an emergency supply of current? Current that comes without even touching a switch, without a perceptible second of darkness.

Dependable Protection

This is the type of lighting insurance that an Exide-equipped Emergency Lighting System offers you. It can be adapted to protect you against lighting interruptions in one or two rooms or throughout the entire hospital. Then, your worries are over. With this system eternally vigilant, light is unfailing.

The system is operated by an Exide Emergency Lighting Battery, which is maintained in a fully charged condition at all times by current from the main power line. When the main current supply is interrupted, this battery instantly and automatically begins to deliver current to all lighting circuits con-

nected to it. These circuits may carry the regular lights or special lights installed for emergency purposes only.

The Exide-equipped Emergency Lighting System needs little operating care and attention; upkeep expense is negligible; cost is so flexible, that no matter how limited your budget, there is a system to fit your emergency needs.

Let an Exide engineer call and consult with you. Without the slightest obligation to you, he will study your needs and make specific recommendations. Write today!

Clipping from
page 1 of the
"Philadelphia
Bulletin" of
May 3, 1927

LIGHT FAILS AT OPERATION
Bryn Mawr Hospital Emergency System, However, is Put in Use
An emergency lighting system was put into use today in the operating room of the Bryn Mawr Hospital when the power failed while an operation was being performed.
The rest of the hospital was virtually without light for about a half hour. The failure of the power was due to the rebuilding of the power road near the hospital.
An appendicitis operation was performed by Dr. [Name] when the power failed, throwing the operating room into darkness. A switch was then thrown, connecting a storage battery emergency power unit.

Exide

BATTERIES

THE ELECTRIC STORAGE BATTERY COMPANY, Philadelphia

Exide Batteries of Canada, Limited, Toronto

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OUT-PATIENT SERVICE

Conducted by MICHAEL M. DAVIS, Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 151 Fifth Avenue, New York
A. K. HAYWOOD, M.D., Superintendent, Montreal General Hospital, Montreal, Que.

NORTH END COMMUNITY CLINIC BROADENS ITS SERVICE

By Eleanor Jones Ford, Director, North End Community Clinic,
Detroit, Mich.

THE opening of the Leopold Wineman Memorial Building in August, 1926, to house the North End Community Clinic, Detroit, Mich., marked an important milestone in the life of this clinic.

Started twenty years earlier by the United Jewish Charities, under Blanche Hart, first as a baby clinic, with Dr. Rowland in charge, and about the same time as a medical clinic under Dr. Hugo Freund, to provide physical examinations for the families under the care of their social service department, the clinic grew steadily until about five years ago it was moved to two small store buildings and was opened as a neighborhood clinic to

which were admitted all people eligible for clinic care, irrespective of race or creed.

This was the first step in the far-sighted plan of the present chief-of-staff, who saw the need for a neighborhood clinic in this section of factory workers and small businesses, a section difficult of access to the established out-patient departments in the city, because of transportation problems. Shortly after the clinic was opened in that location it was given into the care of the Fresh Air Society, whose keen interest, generosity and understanding helped greatly to make possible the program now being undertaken so that fuller service may become possible.



The pediatric waiting room, North End Community Clinic, Detroit, Mich.

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Fire Alarm Control Panel
in Case



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Mechanical
Bell



Double Gong



"MD"
Fire Alarm
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"Reacto" Horn



Station Call Case



Type "S A"
Fire Alarm
Station



"E T S"
Fire Alarm
Station



Type "H"
Fire Alarm Station



Type "S" Bell



Single Stroke Bell

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Holtzer-Cabot Fire Alarm Apparatus is of the latest design, will meet every requirement, and is 100% dependable.

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ELECTRIC COMPANY**

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SAID THE CONTRACTOR TO THE ARCHITECT---

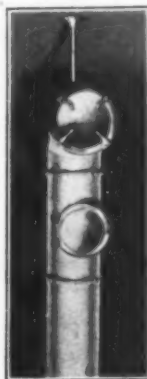


"I WANT to congratulate you on that last laundry chute you specified. Shipment was made on time, parts were all properly boxed and tagged, erection was handled in record time because the chute exactly met your specifications, and I was particularly impressed with the low price. The fact of the matter is, I had no idea that a standardized laundry chute could be had so cheaply."

To which the architect replied (*commenting inwardly upon his ability to please the most meticulous of contractors, but at the same time not wanting to take too much glory to himself*):

"Yes, I would have specified this chute* on the last half dozen jobs if I had known about it."

*There is no secret about the identity of the above mentioned chute. It is made by Pfaudler, manufacturer of laundry chutes for over 15 years.



As a result of a new method of fabrication and without sacrifice to its established quality, we are able to offer the glass-lined laundry chute at greatly reduced prices. Consequently the most sanitary and durable construction yet devised, is well within the scope of even a modest financial building outlay.

Both the glass-lined and aluminum laundry chutes are fully described in a new brochure. Write for your copy today!

THE PFAUDLER COMPANY
Laundry Chute Division, ROCHESTER, N. Y.

LAUNDRY CHUTES
PFAUDLER

The need for this expansion seems to have been justified by the attendance during the first six months the clinic has been in operation in its present quarters. There has been a steady increase. In January the number of visits was twice that recorded for the same month the year before, and the growth is continuing. The long continued unemployment situation in Detroit has had much to do with this. However, expanded and additional services, more attractive surroundings and wider publicity through newspaper articles have also played a part.

Every patient before admission to the clinic is interviewed in regard to income, indebtedness, occupation and regularity of employment, whether property is owned, the size of the family, the number of dependents and the health of each member of the family, so that only those may be admitted who are entitled to care here.

The present building, the Leopold Wineman Memorial, has received much favorable comment not only in Detroit but in other sections of the country, and from people who are informed regarding such buildings and their needs. At the suggestion of Michael M. Davis, executive secretary, Committee on Dispensary Development, New

On the right as one enters is the isolation suite through which all children pass to be inspected by a nurse for signs of communicable disease. Here they are detained for examination by a physician when necessary. If an infectious disease is found they are sent to the proper place, in the ambulance of the city infectious disease hospital, without coming in contact with any other patient.

The medical service for adults is in the rear of the first floor; the laboratory and x-ray rooms adjoin. Pharmacy is on the exit corridor. This department follows the plan of the Boston Dispensary, Boston, that is, a formulary (an accepted group of prescriptions covering all needs) is used by the medical staff, and these preparations are kept on hand in necessary quantities, in the proper sized packages for dispensing. This enables the patients to get their medicines without unnecessary delay during clinic hours, and the stock is replenished during the quiet times when the clinic is not in session.

On the second floor in the rear is the pediatric division and in the front the various branches of surgery: general surgery, gynecology, urology, orthopedics, ear, nose and throat, eye and dentistry; also psychiatry, neurology and



North End Community Clinic, Detroit, Mich.

York, who acted as consultant, the building was planned from the standpoint of the services to be performed, keeping in mind those services that would be linked, what steps would be taken in performing them and by whom they would be performed. Cross ventilation, outside light in every portion of the building, the placing of entrances and exits, and the avoidance of cross traffic by the patients were also carefully considered.

Sunny, buff walls, walnut finished wood furniture, and French gray metal furniture make the interior attractive. To give the main halls outside light and ventilation all offices and waiting rooms are alcoves or extensions from them. To avoid crowding at the entrance, the registration desk, unlike the usual custom, has been placed as far from the entrance as possible, near the center of the first floor. The information desk, admitting office and waiting room for new patients are on the left, nearer the front.

dermatology. Near the dental, ear, nose and throat and surgical rooms is a recovery room with a lavatory attached, where patients may rest for a short time when necessary. This recovery room is reached from these departments through a closed corridor, so that contact with waiting patients may be avoided. A substation office for the visiting nurses is also on this floor.

In the afternoons, the pediatric department is used by the department of health for well baby and preschool clinics; the front of the second floor by the staff of the North End Clinic for physiotherapy treatments—baking, diathermy, Alpine light, massage, muscle manipulation. In the near future it will be used also for scoliosis cases. For the latter, mirrors have been installed on the doors of the surgical room so that each child may see the improvement in posture that his muscle training exercises bring. The department of health also holds prenatal clinics here.

Color in Hospital Furnishings

The new note in hospital furnishings is more color. It is realized that white and drab surfaces are not necessary to sanitation, and that colorful surroundings have a beneficial effect upon patients. By the use of washable fabrics and surfaces, hospital rooms may now enjoy cheering and restful color schemes.

Marshall Field & Company's Contract Division and Interior Decorating sections, after vast experience in furnishing and decorating residences, hotels, clubs, theatres and churches, are now giving special attention to the possibilities of hospital furnishing. Recent installations are bringing forth enthusiastic commendation. The use of specially woven sunfast and tubfast damask, with walls tinted to match, has been heartily endorsed as a means of giving rooms color and refinement.

Communications from hospital authorities are invited.

CONTRACT DIVISION MARSHALL FIELD & COMPANY

121 North State Street Chicago



Dougherty's No. 5629

No. 5629 Bedside Table

Standard Equipment

Constructed entirely of steel. Panelled sides. Double box constructed doors with improved snap fastening. Swinging bracket complete with 12½" deep form basin. Toilet paper holder on inside of door, towel bar on back. Separate compartment for bed pan. Patient's drawer 2" high.

Dimensions: Top 15½" x 19" x 32" high.

Polished Plate Glass Top, Extra

Finished in Dupont's Duco, can be supplied in a wide range of colors.

H. D. Dougherty & Company
Phila. Penna.

The building contains cloakrooms for the physicians and for the general staff. On each floor are lavatories for the patients and service rooms for nurses and for janitors. Ample storerooms are conveniently placed in the basement. There are three waiting rooms, one for each group of examining rooms—medicine, pediatrics and general surgery. A drinking fountain is in each waiting room.

The walls throughout are of hollow tile to insure sound-proof rooms for the necessary quiet during examinations, and for privacy. All cupboards are raised on a six-inch terrazzo base to protect the lower shelves when the floors are scrubbed. As much of the furniture as possible is fastened to the walls to facilitate cleaning. The floors are terrazzo, with sanitary bases. Oil is used for heating but all arrangements have been made so that coal may be substituted if necessary at any time. The foundations and heating capacity have been planned for two additional floors. There is also additional ground for expansion.

Ann Arbor Clinic Is Model

Before the building was completed there was an opportunity to develop a diabetic clinic along the lines originated at Ann Arbor, Mich., and as the basement was the only part of the building for which services had not been planned, it was necessary to adapt it as well as possible to such a department. Because of lack of hospital beds some years ago, the University Hospital, Ann Arbor, opened a diabetic dining room in which hospital service was provided for ambulatory diabetics, who could board in Ann Arbor. In this way the tolerance of these patients could be established as accurately as if they had been hospitalized and they came to this clinic three times a day for meals and the necessary laboratory tests.

To establish an individual's tolerance a very scant diet is given to which additional food is gradually added. During this time careful laboratory tests are made to ascertain the effect of the extra food and to indicate when the maximum for each patient is reached. This amount is the individual's tolerance.

The patient is carefully instructed as to diabetic diet in general, and specifically as to the food he, individually, can handle with impunity. He also is taught how to make simple laboratory tests that will at all times indicate his condition. If these instructions are followed, unless some other illness should occur, the patient should remain well and be able to lead a normal life.

The physician in charge of the diabetic department of the North End Clinic feels strongly that such a service, operated in an industrial center, especially one in which hospital beds are far below the requirements, would be a boon to many diabetics, first, because they could thus receive the accurate service that only hospitalization otherwise gives; second, because they could do so without giving up their occupations; third, because they could save the expense of a hospital bill; fourth, because their tolerance could be ascertained under their usual living conditions, rather than under the artificial ones of rest in hospital beds; fifth, because the hospital beds could be saved for those that could be properly cared for only in such a way. The North End Clinic is attempting to give such a service.

This service is open not only to clinic patients but, like all hospital service, to patients of private practitioners desiring to use it. The last group, of course, pays full cost when able to do so, or such portion of it as their physicians deem they should pay. The clinic patients, when able, pay the cost of the food, the insulin and in some instances a laboratory charge, just as at Ann Arbor. The response to this service has been surprisingly great.

Since half of the patients to date have been orthodox Jews who strictly conform to the Jewish dietary laws, the cooking and diets are in accordance with these laws. This however in no way limits the service to this group. Sixty per cent of the patients are Jewish.

A graduate dietitian with a number of years' hospital experience is in charge of the dietetic service. This is available for other departments as well as for the diabetic.

We are especially interested in our work with children and their parents. No child is admitted unaccompanied by a parent, guardian or some older responsible person. The financial interview does not take place in the hearing of the child, nor is an examination made unless some older person is present. We feel that parents should be interested in and informed regarding the health of their children and that the children should be kept from a knowledge of the financial circumstances of their parents during the years it is customary to have such protection. The physicians need to know, too, such facts as only adults fully acquainted with the children's habits of life can supply. It is difficult for many parents of families to come to the clinic with their children, but the greatest kindness and help that one can give these little children is to make it possible for the parents to give them the same care and have the same knowledge of them and their needs as do the parents of children in more fortunate circumstances. It is not a kindness to follow the line of least resistance and deprive them of this. With effort, it is usually possible to make the necessary adjustments so that the proper adults may be present.

There is at the North End Clinic a children's worker who is a graduate in nutrition of Simmons College, Boston, with one year's experience at the Ruggles Street Day Nursery, Boston, and another at the Merrill-Palmer School, Detroit. She looks after the children who come to the clinic exhibiting fears of any kind, especially fear of medical care, and children who display temper tantrums or have bad food habits. This worker establishes a friendly understanding with these children and their parents, and helps the latter to make the necessary corrections in discipline and environment. She also helps the children to approach the clinic and all medical care in a spirit of confidence and cooperation instead of fear. The results have been gratifying.

Nursery School Is Needed

The need for a nursery school as a therapeutic agent is becoming more and more apparent and we hope some time to have one in connection with the clinic, to which the doctors may send children who need training in habit formation, just as others are sent to convalescent homes, fresh air camps, hospitals or schools of various kinds. At the Merrill-Palmer School is one child who exemplifies what such facilities can accomplish. This unusually bright little girl of three had all her life refused every food but liquids, and of course she is very small.

An evening clinic is held twice a week from five to seven o'clock. This includes social hygiene, medicine, pediatrics and dentistry, and is designed for wage-earners and school children.

Needless to say there is a social service department connected with every service offered.

About a year ago because of the developing program, the Fresh Air Society relinquished control of the clinic, which now has its own board, elected at the annual meeting of the Jewish Federation. The present officers are: Jesse F. Hirschman, president; Julian Krolik, vice president; Mrs. Samuel Mendelsohn, treasurer; Edith Heavenrich, secretary.

Now~Pure Refined Coffee

90% free from caffeine

Laboratory tests

... show that 90% of the caffeine and practically all of the free tannic acid have been removed from Blanke's Refined Health Coffee.



Physicians are prescribing this pure refined coffee in cases of various nervous disorders with resultant benefits

Blanke's Refined Health Tea

with 70% of the Tannin removed is made by the same refining process.

Hospital size (1600 cups) . \$6.50
Household size (400 cups) 1.75
Kitchenette size (200 cups) 1.00



HERE is a pure, refined, soluble coffee free from poisons, impurities and adulterants—a coffee which can safely be used by invalids as well as those who cannot enjoy ordinary coffee without suffering from its after-effects.

Blanke's Refined Health Coffee is truly a health drink. Its delicious genuine coffee flavor is pleasant to everyone. Its color, its mellowness—all appeal to those whose appetites long for real coffee.

Blanke's Refined Health Coffee has all the pleasing benefits without the disturbing effects of ordinary coffee.

Any sleeplessness which is occasioned the confirmed coffee drinker by his favorite beverage is entirely eliminated when Blanke's Refined

Health Coffee is used—the stomach reactions are notably less and there is no after-depression from overstimulation.

Physicians will find Blanke's Refined Health Coffee especially beneficial in the diet of various nervous disorders.

Try this pure coffee, which comes in soluble form.

In addition to its other desirable qualities, Blanke's Refined Health Coffee is always ready to be served instantly, simply by adding hot water. In the hospital, at the bedside, or in the home at meal time, Blanke's Refined Health Coffee is quick and easy to prepare.

Druggists are being supplied with Blanke's Refined Health Coffee in these sizes.

[Hospital Size (480 cups) \$6.50. Household size (120 cups) . . . \$1.75. Kitchenette size (60 cups) . . . \$1.00.]
If your druggist can not supply you, send his name and a check for the size can you want and it will be mailed to you promptly.

BLANKE HEALTH COFFEE AND TEA CORP., ST. LOUIS, MO.

BLANKE'S REFINED HEALTH COFFEE

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and
Housekeeping Problems

Conducted by C. W. MUNGER, M.D., Director,
Grasslands Hospital, Valhalla, N. Y.

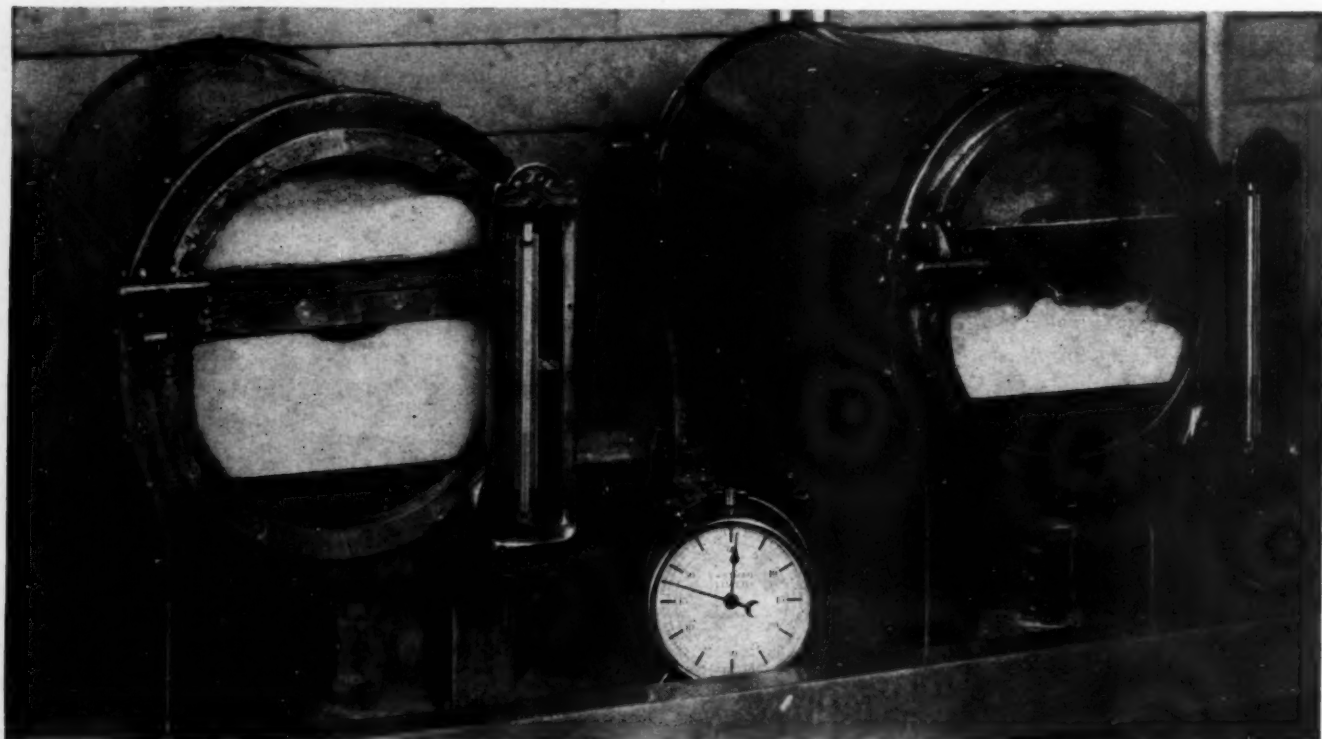
PROTECTING COLORED CLOTHING THROUGH PROPER LAUNDERING

THE safe washing of colors has always been a problem for the laundryman. The public, in many instances, has had unpleasant experiences with the colored garments sent to the laundry, and as a result one finds that many home managers still believe that it is not safe to trust the laundry with colored clothes.

A study of the true conditions indicates that there is no question that some of the colored clothes have been faded in the laundry. The responsibility in many instances, however, rests with the textile manufacturer and in turn with the public as well as with the laundry owners. Many colors that bleed in cold water alone are sent to the laundry, so that the laundry cannot be expected to handle such colors successfully. A large share, if not the majority of the so-called light colors such as are used for bungalow

aprons, house dresses and children's clothes, will not stand washing above 100° F. without bleeding. This is due to the type of dye used, and so long as the public demands, through price, such a dye, and the textile manufacturers produce fabrics of this type, the laundry owner will have to exercise extreme care in order to retain the original color.

There are available fabrics that will withstand washing at 180° F. without materially changing their color. Such fabrics are in the minority, however. There are also fabrics that bleed in cold water, which are also in the minority. The majority of the colors received by the laundry today may be handled with safety and satisfaction, provided the proper classifications are made and the temperature does not exceed 100° F. at any time. The



The laboratory washer on the left contains the suds of a special cold water soap. The one on the right contains regular tallow soap. The water in both was cold, less than 70° F. Both were run the same length of time. Notice the difference in the sudsing qualities.



*for
strength*

THE GIANT, WEAR, SNATCHES EVERY SHEET—strains at every fibre of it—ruthlessly seeks its destruction. In a Pequot Sheet, tough, uniform STRENGTH resists him!

Only strong, healthy fibre that has survived the rigid examination of the testing room is ever permitted to begin its journey through the mill. Once on its way, machines of almost human intelligence watch with mechanical tirelessness the progress of every single thread, from bale to finished fabric, ready to pounce upon the slightest weakness and stop that thread from reaching the loom.

That means to you the utmost in wear, with no weak spots. Pequot sheets go regularly through the ordeal of the laundry and return to you strong, sturdy, ready for strenuous use.

The snowy whiteness and exquisite “feel” of Pequot have long been a tradition. And they are both part of that *strength* that is your surest economy.

Naumkeag Steam Cotton Company,
Salem, Mass. Parker, Wilder & Co., New
York and Boston, Selling Agents.



"For the Life of Your Building"



Polyclinic Hospital, Harrisburg, Pa.
Equipped with Chamberlin through-
out for permanent protection. Kost
& Kelker, Harrisburg, Archts. W.
E. Bushey, Lemoyne, Pa., Contr.

YOU provide for permanent weather stripping protection when you include Chamberlin equipment in your hospital plans. Chamberlin equipment means a scientific weather stripping installation and a weather stripping service that endures "for the life of your building". Trained Chamberlin mechanics install every inch of Chamberlin equipment and Chamberlin assures lasting satisfaction by a dependable and permanent service guarantee.

Chamberlin equipment, including Weather Strips, Plasti-Calk and In-Dor-Seals, is particularly essential in the modern hospital. Chamberlin Weather Strips bar out chilling draughts, dust and soot. They deaden traffic sounds while Chamberlin In-Dor-Seals on interior door bottoms eliminate corridor noises and the free circulation of cold night air—they confine diet kitchen and operating room odors to the areas in which they originate. In addition to these benefits, Chamberlin equipment assures a substantial yearly fuel saving. Your hospital needs Chamberlin equipment.

Write for Chamberlin Literature



CHAMBERLIN METAL WEATHER STRIP COMPANY
West Lafayette Blvd., Detroit, Michigan

Over 100 Sales and Service Branches throughout the United States

following classifications of materials should be made:

1. Silks
 - (a) Fast at 100° F.
 - (b) Fugitive at 100° F.

If a color bleeds in cold water alone, it will be necessary to wash it by itself, reducing the actual handling to a minimum, as by hand washing. The silks fast at 100° F. may be washed with a pure soap in the regular wash-wheel. Care should be taken to have a high suds and sufficient water in the wheel to reduce mechanical pounding to a minimum. Delicate garments should be washed in nets. Do not use bleach.

2. Woolens
 - (a) Fast at 100° F.
 - (b) Fugitive at 100° F.

The same care, so far as classification is concerned, should be taken as in handling the silks.

When washing woolens, avoid mechanical pounding and any drastic change in temperature. The temperature should be constant for all operations and should not exceed 100° F. A neutral soap should be used and a high suds built in the washer before adding the woolens. Care must be taken to have a high suds water, ten to twelve inches, in order to avoid too much mechanical pounding. The wheel should be stopped between operations while draining and refilling. The number of suds required will depend upon the amount of water present.

3. Cottons
 - (a) Fugitive
 - (b) Dark Colors.
 1. Body clothes
 2. Hosiery
 3. Overalls
 - (c) Light Colors.
 1. Solid
 2. White checks or stripes
 - (d) Shirtings and fast colors.

The fugitive colors (those that will bleed in cold water alone) should be handled separately.

The three dark colored classifications listed should be handled separately. The body clothes may be washed by the multiple suds formula, omitting the bleach and keeping the temperature below 100° F. The hosiery may be treated in a similar manner.

The overalls may be washed by the multiple suds formula, omitting the bleach and reinforcing the usual soap and builder on the first two operations, with an additional quantity of builder; that is, for every pound of soap and builder used, add one pound of soda ash or its equivalent on the break and first suds.

Light Colors Need Care

The greatest care should be taken with the light colors, especially those containing white checks, stripes or collars. This classification receives the most careful inspection by the housewife and in the past has been the source of many complaints. There is no secret in the safe washing of this type of color, unless temperature and classifications may be called a secret. Inasmuch as it will be necessary to wash at a relatively low temperature, it will be necessary to use a soap that will be most efficient at that temperature.

So far as the choice between washing at 100° F. or with straight tap water is concerned, it is a matter of personal judgment. "The higher the temperature, the more efficient the wash so far as dirt removal is concerned," is a fundamental that still holds good. If it is possible, therefore, to control the temperature so that it will not exceed the danger line it would be desirable to

The best way to buy "Lysol" Disinfectant



Made by Lysol, Incorporated, a division of Lehn & Fink Products Company. Sole distributors, Lehn & Fink, Inc., Bloomfield, New Jersey.

In Canada, Lysol (Canada) Limited. Distributed by Lehn & Fink (Canada) Limited.

Lysol
Disinfectant
REG. U.S. PAT. OFF.

WE have a new plan which enables you to contract in advance for your year's supply of "Lysol" Disinfectant.

Delivery is made as you desire during the year following the date of the contract.

The prices under this purchase plan are greatly below our regular prices—the reduction being governed by the amount ordered.

This offer is open *only to hospitals*.

This, we believe, makes it unnecessary for any hospital, however large or small, to endanger the reputation of the institution, the members of its staff, and the safety of its patients by using an inferior disinfectant.

Mail the coupon below. We will send you promptly the details of this "yearly purchase plan."

LEHN & FINK, INC., *Sole Distributors*
Dept. H13, Bloomfield, N. J.

Send us your NEW offer for supplying "Lysol" Disinfectant.

Name of hospital.....

Street.....

City..... State.....

Name of buyer.....

No. of beds..... Title.....

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For complete index of advertisements refer to the Classified Directory

They meet standing orders on many diets —these tempting desserts

A Cereal Chocolate Pudding

$\frac{3}{4}$ cup Cream of Wheat (uncooked) 1 cup sugar
4 cups milk Whipped cream
2 eggs $1\frac{1}{2}$ squares chocolate (melted)

Scald milk. Slowly add Cream of Wheat and chocolate. Cook 20 minutes. Add beaten egg yolks mixed with sugar, and stiffly beaten whites. Cook 5 minutes longer. Cool, and serve with whipped cream.

Dietitians, who must constantly give variety within the requirements of standing orders on different diets, will find a light, dainty pudding like this of great help in menu planning. It is one of many tempting dishes easily made from Cream of Wheat. Such dishes are pleasing to your patients—nearly all of whom can eat Cream of Wheat in some form—and consequently simplify the problem of special orders to be prepared by cutting down their number.

In leading hospitals today Cream of Wheat—for years as standard as the baked potato—is constantly used for a variety of dishes.

For thirty years physicians have endorsed it as a hospital food for the following reasons:

1. Its high starch content, which gives just the right nourishment.
2. Its simple granular form, which insures easy digestion.
3. Its triple-wrapped-and-sealed package which shuts out all contamination.
4. Its uniform quality, year in and year out.

Cream of Wheat has the additional advantage to dietitians of being inexpensive. 40 generous servings—at less than 1c each—in every 28 ounce box! This is a big factor, especially in wards, where expenses must be kept down.

Many other recipes, as delicious and practical as the one given above, are in the recipe booklet, "50 Ways of Serving Cream of Wheat." It gives new ideas to fit many standing orders at small cost. Send for it. It's free.

FOR THIRTY YEARS A STANDARD FOOD
ON PHYSICIANS' DIETARY LISTS

Cream of Wheat

Cream of Wheat Company, Minneapolis, Minnesota
In Canada, made by Cream of Wheat Company, Winnipeg

© 1927, C. of W. Co.

wash at the highest temperature possible, in this case 100° F. If it is not practical to depend upon the washman to obtain the temperature desired, it is much better to instruct him to use straight tap water only. There will then be no danger of the temperature of the water exceeding 100° F.

What Soap Tests Reveal

A realization of the importance of the safe washing of colors was the reason for a thorough investigation of this problem by our manufacturer of laundry supplies. Many tests have also been made in the experimental laundries and in plant laundries under actual operating conditions. The various types of soap stocks were tested, as well as different types and combinations of builders. One of the interesting points brought out by these experiments was that, all other things being equal, the quantity of soap necessary to form a suds at and above 100° F. is practically the same, regardless of the type of soap stock used. When washing below 100° F. and especially at 60° F., there is a considerable difference in the quantity of soap required to form a satisfactory washing suds with the so-called hot and cold water soaps. This is due, apparently, to the characteristics of the soap stocks used.

The following qualities are essential to a good cold water soap:

1. It must be a good detergent. This is very important, since cold water itself immediately handicaps the washing process, that is, all other things being equal, the higher the temperature the more efficient the wash, so far as dirt removal is concerned. The cold water wash must not, therefore, be further handicapped by the use of an inferior detergent.

2. It should be uniform in composition. A uniform product, in which the ingredients are carefully blended, is not only pleasing to the eye but it is reliable. Since cold water soaps are used almost entirely for the washing of colors, it is important that we have a uniform product, if we wish to obtain uniform results.

3. A pleasant odor is highly desirable. Soap with a strong odor, either natural or artificial, has a decided tendency to transfer the odor to the washed fabric. This tendency is most pronounced in cold water. It is essential, therefore, that the cold water soap should have a pleasant odor, otherwise the odor left in the clothes will have to be counteracted in some artificial manner, such as, for example, heavy souring.

4. Good "sudsing" properties are essential. In general the lower the temperature of the wash the poorer the sudsing properties of the soap. The difference in the sudsing properties of the so-called low-titre and medium-titre soaps is marked and readily noticeable in cold water. The washman stops adding soap to the wheel when he has obtained a good suds in the washer. If the cold water soap does not go into solution quickly and build a suds readily, much soap and time are wasted.

Qualities Essential in Cold Water Soap

The safe washing of colors depends largely upon the use of the proper temperature. The economical washing of colors at the proper temperature depends largely upon the type of soap used. A good cold water soap has the five following properties: It is a good detergent; it is uniform in composition and has a pleasing appearance; it has a light and pleasant odor; the sudsing properties are the best obtainable under the temperature conditions specified; it may be used with economy, for it will suds readily at the temperature necessary for the safe washing of the color.



A Real Spread for Bread

Known to be wholesome
in the making—clean in
the wrapping.

Has won universal favor
because it *tastes* so good!

And, used unsparingly,
you can't make it an ex-
travagant item of the diet.

Swift & Company
U. S. A.

Premium Oleomargarine

"Tastes as good as it looks"

Junket and Milk—*Partners in Health*



Junket

*adds delightful variety
in routine diets*

OF course you know how delicious junket is—the indispensable daily quart of milk never ceases to be enjoyed when served as dainty junket. By adding fruit, nuts, whipped cream, or a fancy topping, you can quickly have an attractive dessert for each day's tray—every one of them wholesome and nourishing. But do you realize that junket also

*Serves a definite purpose
in therapeutic diets*

Naturally, junket is a staple in any diet planned for the child suffering from malnutrition, as it should be in that of the well child to be guarded against under-nourishment. In almost any standard diet list you'll find Junket prescribed in the proper feeding for obesity, typhoid, pneumonia, diabetes, and other cases too numerous to mention. Pound cans of Flavored Junket, and Tablets in packages of 100, are specially prepared for hospital use.

Junket

Free, on request, "Junket in Dietetics"—an authoritative booklet for the use of physicians, nurses, and dietitians.

THE JUNKET FOLKS
Chr. Hansen's Laboratory, Inc.
Dept. 76, Little Falls, N. Y.

In Canada, Chr. Hansen's Laboratory, Inc., Toronto, Ont.



An "R. H. S." Case
All Roaches Killed by
Whiz FLY FUME

HOSPITALS and all public institutions are constantly troubled with roaches, water bugs and other insects. The best and safest way to keep rid of these is to spray all cracks, corners and crevices with **Whiz FLY FUME**. It kill roaches and other insects.

Sold in 5-gallon cans and 30- and 60-gallon drums.

Whiz FLY FUME is an insecticide of superior effectiveness manufactured by a company which has sold Whiz Quality Products all over the world since 1898.



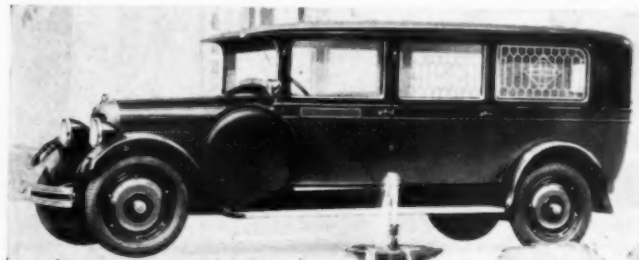
MANUFACTURED BY

The R. M. Hollingshead Co.
Camden, N. J.

SPECIAL MODEL AMBULANCE

An ambulance especially designed as the result of suggestions from many hospital superintendents, physicians and nurses who attended the Atlantic City meeting of the A. H. A. has recently been placed on the market. It is mounted on a chassis of unusual strength, having a wheel-base of 146 inches, balloon tires and resilient springs.

Protection from drafts is assured by a particular type of windshield that gives the car a complete change of air every five minutes. Adequate ventilation is provided even in severe storms, troughs beneath the cowl carrying off



the water that trickles down the windshield. An electric fan and a special heater help to maintain proper temperature.

The patient's compartment is lined with gray leather and the floor is covered with heavy linoleum. The windows are fitted with roller shades. The folding chair cot is securely fastened on the left by special cot hooks and may be loaded from either the side or rear doors. Folding seats for two attendants are also provided.

The driver's compartment is also upholstered in gray brocaded leather with side linings to match.

The ambulance is completely equipped with the latest accessories.

COMBINATION BEDSIDE AND FOOD TABLE

A combination table consisting of a bedside and a feeding table has been developed and placed on the market, in response to the solicitation of many medical directors and superintendents whose requests demanded a table to meet both requirements.

First of all the table had to be a practical outfit, simple of operation. It must not take up a great amount of floor space and the food tray must be elevated high enough to clear the bed and be strong enough to support the necessary weight.

All these features are embodied in this design. The method of extending and elevating the food table is simple but positive in action. It has no gears, pawls, or springs, so that the locking device is unusually strong and serviceable.

The food tray can be adjusted in height from twenty-seven to forty-one inches and will support forty pounds. The floor space occupied with the tray down is sixteen by twenty-four inches and with the tray extended is sixteen by thirty-eight inches. The food tray can be removed with one hand, allowing cleaning or other adjustments for which this feature provides.

The bedside table is sixteen inches wide, sixteen inches deep and thirty-four inches high and can be furnished in a number of styles and finishes. It can be designed with the food tray on the back or on either side, as desired. The table has one drawer and one compartment fitted with a door.



Soap cannot be made too pure

It is not surprising that hospital authorities agree with us on this point. And this is doubtless the reason why hospitals welcomed Ivory Soap when it first appeared on the market nearly half a century ago.

Ivory, as all the world knows, is 99-44/100% pure. Its ingredients, therefore, necessarily are unusually fine. You are convinced of this when you first use Ivory. It lathers richly, cleanses thoroughly, rinses readily and leaves the skin in a delightfully refreshed condition. Because of its gentleness it is considered the ideal soap for cleansing the sensitive skin of tiny babies.

Ivory is inexpensive, too. The purchase of Ivory necessitates no increase in your budget.

In addition to the familiar household cake in which form Ivory first was manufactured, there are today smaller, individual sizes which are especially suitable for hospital use. If you will drop us a line, we shall be pleased to mail you sample cakes of the five new miniature size of Ivory.

PROCTER & GAMBLE
Cincinnati, O.

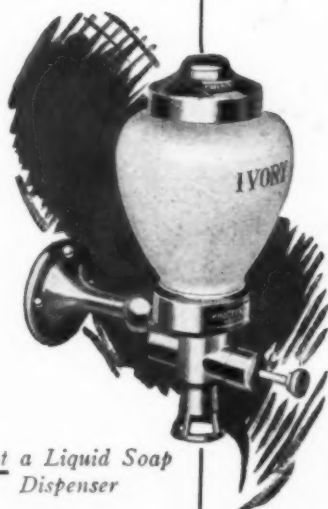
The Ivory Soap Dispenser—

Designed for public washroom use.
Admirably suited to the use of doctors and nurses in the wash-up rooms

**Sanitary — Economical
—Ornamental**

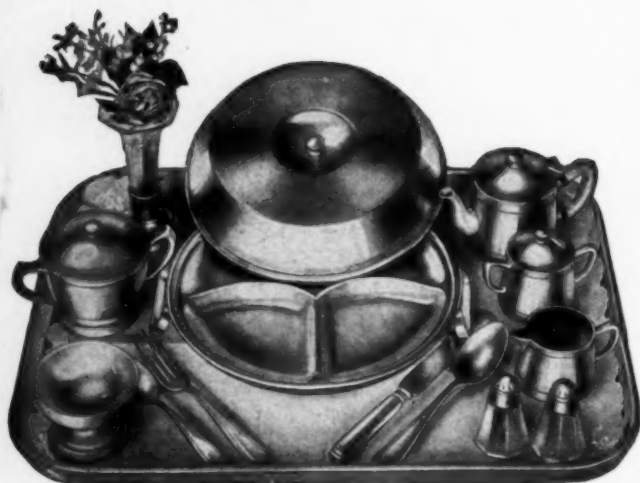
Dispenses genuine Ivory Soap—
99-44/100% pure—in fine flakes.

Write for prices and
descriptive circular.



Not a Liquid Soap
Dispenser

THORNER'S Silver Service



Thorner's Silver Service is made of 18% Nickel Silver with a quadruple silver plate. Wears a lifetime. Replacement through breakage is forever eliminated. It is never affected by wear or polishing.

Illustration features Thorner's Improved Three Compartment Hot Water Plate. Tea Set with reinforced bands, hard metal hinges, Silver Soldered and one-piece unbreakable bottom. Covered Soup Cup with Silver Soldered handles. Sherbet Dish, Individual Bud Vase, Salt and Pepper Shakers, and Superior Grade Sectional Plate Flatware.

Visit our exhibit at
the Catholic Hospital
Association Convention,
June 20 to 24,
at Milwaukee, Wis.,
Booth 13.

THORNER BROTHERS

Importers and Manufacturers of
Hospital and Surgical Supplies

386-390 Second Avenue
NEW YORK CITY

UNIFORM, SHADOWLESS ILLUMINATION FOR OPERATING ROOMS

The solution of the problem of securing for operating rooms a uniform artificial light, free from shadows that seriously interfere with the surgeon's work, has been approached by manufacturers in different ways. In all cases, a battery of arc or nitra lamps is arranged star or circle fashion, either directly above the operating table, on the ceiling or the walls, or on both. However, the

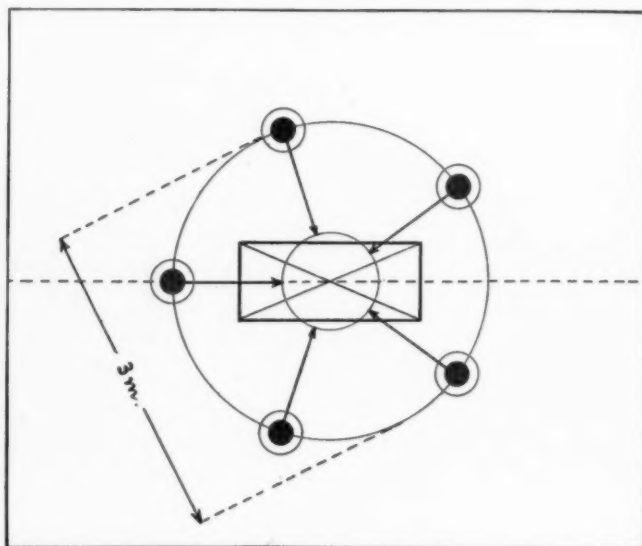


Diagram showing arrangement of five reflector lights around the operating table.

lamps are either too close to the operating table, radiating heat and spreading dust, or if far enough away, the light is too dim and not shadowless.

During recent years some of the most satisfactory



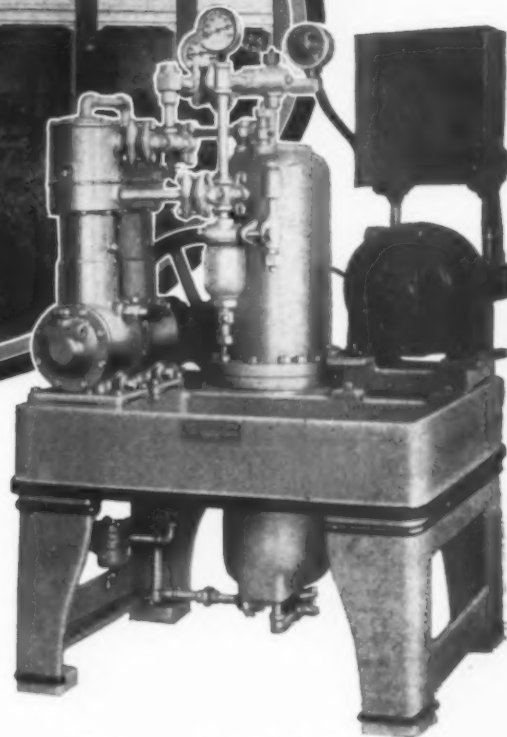
Gynecological operating room of the University of Jena, Germany, showing stationary reflector lamps on the walls, and a portable reflector lamp on a tripod near the center of the window

installations have been made with ball reflector lamps. Their easy installation, simple adjustment, entire absence of blinding glare and negligible heating effect, have made them standard equipment in many of the best equipped hospitals.

Usually a group of five lamps is arranged concentrically

Lipman

AUTOMATIC REFRIGERATION



"Cold" ~ when and where you want it

Lipman Full-Automatic Refrigeration, besides dependability and economy of operation, possesses a feature of outstanding importance to the modern hospital. One Lipman Machine, of proper capacity, will refrigerate the ice-boxes, the drinking water, biological cabinets, and the mortuary. In addition, it will provide ice in large blocks for packing and in cubes for cooling drinks. We call this the Lipman Multi-Temperature feature, and it is a point we should be glad to explain to every hospital manager.

Your request for information will receive prompt attention. Use the convenient coupon below.

Lipman Model 206 Refrigerating Machine installed at Nurses Home, National Military Home, D.V.S., Dayton, Ohio. Lipmans are available in sizes and capacities for every service, all soundly engineered, soundly built, and known everywhere for economical and dependable performance.

GENERAL REFRIGERATION COMPANY

117-193 Shirland Ave.

Beloit, Wis., U.S.A.

Please send me full particulars including Free Descriptive literature on Lipman Refrigerating Machines.

Name..... St.....
City..... State.....

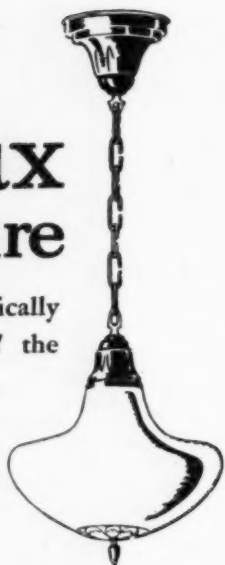
THE DRY, CONSTANT COLD OF THE MOUNTAIN TOP



The Sol-Lux Luminaire

A lighting unit scientifically designed to utilize *all* the light—without glare.

WESTINGHOUSE ELECTRIC
& MFG. COMPANY
Merchandising Department
South Bend Works
SOUTH BEND, IND.



Westinghouse



Pleasing Appearance of Floors and Walls

when laid with Romany Quarry Tiles is due to the natural "texture" of the tiles themselves. Their colors are uniform throughout, they are practically impervious to moisture and easily cleaned. They are made in three plain colors, Romany Red, Romany Gray, Romany Brown, and in a medley of golden shades the Romany Rainbow.

Member, Associated Tile Mfgs.
UNITED STATES QUARRY TILE
COMPANY
Parkersburg, West Virginia



ROMANY QUARRY TILES

around and above the operating table, resulting in an even, uniform light, so that any shadow, cast by the surgeon's head or hand, is illuminated with light from the other four lamps, the beams of which overlap sufficiently to furnish ample illumination at all times.

For gynecological operations eight lamps are sometimes employed, and in many cases a reflector lamp, mounted on a tripod and movable on casters, is added to light up the table with the operating instruments, or to give additional light at points otherwise not accessible.

The employment of optically correct parabolical mirrors, reflecting all of the light, regardless of the contour and condition of the adjacent ceiling and walls, has made it possible to secure even better illumination with fewer of these lamps, resulting in more economical first cost and lower operating expense, than with the old system.

The lamps are well finished and properly rounded, thus eliminating all objectionable corners that collect dust and are hard to clean.

AN ICE CUBER THAT IS SIMPLE TO OPERATE

The demand for cubed ice has become so general in hospitals, as well as in hotels and restaurants, that a new ice cuber has been put upon the market. The cuber is made in three motor driven models, three belt driven models and one hand power model. These models are designed to fill the needs of various sized hospitals and all work equally efficiently. The hand power machine is capable of turning out from 800 to 1000 cubes an hour,



while the larger machines will make from 2000 to 8000 cubes per hour, depending upon the model chosen.

One of the important features of the new machine is the fact that there are few parts to get out of order or to be replaced. It is also easily cleaned and is so made as to take up a minimum amount of space in the kitchen.

HOW TO POPULARIZE HEALTH LITERATURE

Hospitals are functioning more and more as health centers. They have a strategic advantage in the dissemination of public health propaganda, first, because most persons who visit hospitals are themselves ill or are visiting some one who is already a patient; at such times it is only natural that they are in an especially receptive

The Value of the CO₂ in "Canada Dry"

Look
for the Name



on the Bottle
Cap



Sir James Lowther, the eminent English specialist on dietetics, writing on the subject of carbonated beverages, says: "They assist digestion, facilitate the secretions and excretions of the body, and invigorate the whole human system."

Nature, too, recognizes the value of CO₂, for mother's milk contains 10 per cent carbon dioxide by volume.

The high carbonation of "Canada Dry" makes it especially desirable in the sick-room and it is, in fact, served in many of the great hospitals in Canada and in this country.

The added fact that "Canada Dry" is not a synthetic flavor, but a real ginger ale, made from the highest grade Jamaica ginger, especially commends it to the attention and the confidence of physicians, hospital authorities and dietitians.

"CANADA DRY"

Reg. U. S. Pat. Off.

Extract imported from Canada and bottled in the U. S. A. by Canada Dry Ginger Ale, Incorporated, 25 W. 43rd Street, New York, N. Y. In Canada, J. J. McLaughlin Limited, Toronto and Edmonton. Established 1890.

DOES NOT CONTAIN CAPSICUM IN ANY FORM

Modern Floors

In Modern Hospitals

MORE and more of the modern hospitals are adopting Wright Rubber Tile floors. Quiet, durable, sanitary and easily cleaned, this modern flooring has proven unexcelled from the standpoint of practicalness and economy.

Hospital superintendents will find in Wright Rubber Tile floors, a basic and permanent improvement to their institution. Our latest book "Profitable Floors and Modern Hospitals" contains interesting and valuable information. Send for a free copy.

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WECK CRAFTSMANSHIP SERIES



N^o 1 CRAFTSMANSHIP

The surgeon is a craftsman of the most delicate and precious of all mechanisms—the living mechanism of the human body.

Upon the skill and craftsmanship of his hands and nerves rests life or death.

And back of those skilled hands at their work is the craftsmanship of the man responsible for the condition of the keen surgical instruments upon which the surgeon places so much faith. Upon the faithfulness and the skill of the instrument repair man—himself a craftsman also—depends much in that battle of life or death.

Surgeons who have used Weck repaired instruments know their superior qualities. Weck instruments are not merely repaired—they are reconditioned throughout. Weck manufactures no surgical instruments—but makes a specialty of repairing them.

Mail in your instruments for repair. One week service.

Surgical Instrument Repair Department of
EDWARD WECK & SON, INC.
135 Johnson Street, Brooklyn, N.Y.

mood toward information as to how to keep well. Second, because health information secured at a hospital is trustworthy and the reader knows that neither a patent medicine nor an advertising charlatan is in the background.

At the suggestion of the Department of Health, Albany, several hospitals in New York State are regularly distributing to the public the many excellent pamphlets on health matters that are furnished free of charge by the department. A home-made bulletin rack is the means by which one hospital disposes of hundred of pieces of literature each month.

Racks of this sort, if placed near the lines of traffic for visitors and out-patients, will be well patronized. The value of the dissemination of such knowledge in a community would justify the expense many times over.

AUTOMATIC CONVEYOR TOASTER

A toaster has been invented that operates on the endless conveyor principle. After the bread is placed on the conveyor rack at the front of the toaster, no further attention or handling by the operator is required. The conveyor carries the bread between two glowing elements and by the time the slices arrive at the other end of the conveyor, they are toasted. The slices then drop into a chute and are returned to the operator about four or five inches below the place where they started on their journey.

Scorching of the bread or burning of the edges is prevented by an arrangement of damper controls, which are



also used for regulating the heat for various kinds of bread and for continuous or intermittent service.

Under continuous service, 480 slices of standard size toast can be produced in one hour—every piece evenly toasted and similar in appearance.

VITA glass transmits the valuable ultra-violet rays found in reflected sunlight

VITA glass, tests by responsible authorities have shown, transmits about 65% of the available ultra-violet irradiation from indirect sources.

VITA glass is coming into wide use in hospitals and sanatoria, not only as a therapeutic agent for the cure of specific diseases but as a valuable aid to convalescence. Many physicians are recommending VITA glass for the homes of their patients. Its cost is so low that no one can afford to be without its health value.

We shall be pleased to send you, on request, full details in regard to VITA glass.

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Cholecystography by the Graham Method with

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(Tetra-iod-phenolphthalein Sodium Salt—N. N. R.)



Literature on request to X-Ray Dept., St. Louis

Purified, standardized and clinically tested for both the oral and intravenous methods

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Exceptionally high iodine content, producing dense shadows with normal dosage.

Far lower limits of alkalinity than required for intravenous administration and absence of free acid which would render it inoperative for oral use.

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and Distributors of a complete
line of hospital supplies
and equipment.*

Book Reviews and Current Hospital Literature

THE MEDICINE MAN

By E. C. DUDLEY, M.D., LL.D., Ex-President, American Gynecological Society; President Emeritus, Northwestern University Medical School, Chicago.¹

Seldom is it the pleasure of medicine men to read so interesting an autobiography of another medicine man. Dr. E. C. Dudley, who has had an extremely interesting career in medicine and in hospitals both in the east and the midwest, has autobiographically set down chapters in the progress of American medicine and particularly in his own field in such a straightforward and unusual style that the reader will be held interested until the very last page. The work in the women's hospitals in the State of New York, in several of the Chicago hospitals, work that is being done in the hospitals at Yale-in-China, are chronicled and make excellent reading for the hospital superintendent.

There is nothing too technical in this book for the layman or the nurse and a greater appreciation of the work being done in hospitals in the United States will be the result of its reading.

A MANUAL IN PRELIMINARY DIETETICS

By MAUDE A. PERRY, B.S., Director of Dietetics, Montreal General Hospital, Montreal, Canada.²

This manual is a compilation of the lessons used by the author in teaching dietetics to nurses. The fifteen chapters correspond to the fifteen lessons given in the course. Each lesson includes the lecture on composition, value in the diet and other points relative to food material under discussion, and recipes with directions for preparing and cooking the foods.

One lesson each is devoted to caloric values and food requirements, infant feeding and liquid and soft diets. As this is a preliminary course, diets for metabolic diseases are not included.

AN ANGEL OF MERCY

By REV. FREDERICK A. REUTER, Good Samaritan Hospital, Zanesville, Ohio, and REV. E. J. AHERN, St. John's Hospital, Cleveland.³

"An Angel of Mercy" is a short collection of prayers and reflections for the Catholic nurse. The devotions contained in the prayer book are brief and especially adapted to the busy nurse on duty. It contains the ordinary devotions of the Catholic Church and special prayers for the sick room together with appropriate spiritual advice.

¹ J. H. Sears and Co., New York, 1927.

² The C. V. Mosby Co., St. Louis.

³ John W. Winterich, Publisher, Columbus, Ohio.

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A PHOTOGRAPH CANNOT DO FULL JUSTICE TO THIS RED CROSS REEL

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100% is the standard for bran

THERE are many cases where adding a definite amount of bran to the diet is of great benefit. Not only as a prompt relief from faulty elimination but as a pleasant, safe preventive.

Every physician prefers to deal with *known* quantities. Kellogg's ALL-BRAN may be prescribed with full confidence that the results anticipated will be accomplished. For ALL-BRAN provides corrective "bulk" in a known, definite amount. It is 100% bran.

Part-bran products are usually doubtful—both as to the quantity of bran they contain and the results they accomplish. Some are 50% bran—others 25%—or more or less. In any case, there is no accurate standard by which to gauge their effectiveness.

Kellogg's is delicious to the taste. A prescription patients like to take. It may be served as a breakfast cereal with milk or cream—and with fruits or honey added. Or it may be used in many kinds of cooking. It is sold by grocers everywhere. Made by Kellogg in Battle Creek.

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TRIBES AND TEMPLES

By FRANZ BLOM, New Orleans¹

Once in a while someone has the inspiration and genius to write a really readable scientific book, one which appeals equally to the imagination and the desire for accurate knowledge. Such an one is *Tribes and Temples* from the pen of Franz Blom.

This is a record of the expedition to Middle America conducted by the Tulane University of Louisiana in 1925. It is a human document describing the vicissitudes and joys of a party of archaeologists which conducted explorations in Mexico and Guatemala, traveling over the routes of the Conquistadores, studying the remnants of the wonderful civilization of the Mayas and the records which they have left in stone and fabricated clay. They studied their monuments, the remains of their great temples, they excavated and they made scientific observations of the utmost value. The book is in two volumes of about 250 pages each and Volume I has on its back cover a comparative scale of inches and centimeters which is invaluable to the American reader who has not yet learned to think in the metric system.

Well printed and bound, and beautifully illustrated, this is a book that should be in every hospital library. It will take the convalescent patient far afield, relieve the tedium of his hours of recovery and transport him into a new land of which the average American knows all too little. To the scientific worker in archaeology, it should prove an inspiration and a storehouse of invaluable records.

BOOKS RECEIVED

OBSTETRICS FOR NURSES. By Joseph B. DeLee, A.M., M.D., Professor of Obstetrics at the Northwestern University Medical School; Obstetrician to the Chicago Lying-In Hospital and Dispensary. Eighth Edition, revised. W. B. Saunders Company, Philadelphia, 1927. Price \$3.

INTERNATIONAL CLINICS. A quarterly of illustrated clinical lectures and especially prepared original articles on treatment, medicine, surgery, neurology, pediatrics, obstetrics, gynecology, orthopedics, pathology, dermatology, etc., by leading members of the medical profession throughout the world. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, with the collaboration of Charles H. Mayo, M.D., Rochester, Minn., and others. Vol. I, Thirty-seventh Series, March, 1927. J. B. Lippincott Company, 1927.

EARLY DAYS OF THE PRESBYTERIAN HOSPITAL, NEW YORK. By D. Bryson Delavan, M.D., Formerly Resident House Officer, Presbyterian Hospital, New York; Consultant, St. Luke's Memorial, Ruptured and Crippled Hospitals, New York; president, Russell Sage Institute of Pathology, Grenfell Association of America; trustee, New York Dispensary. With thirty full page illustrations. Published privately. Price \$1.50.

EXAMINATION OF CHILDREN BY CLINICAL AND LABORATORY METHODS. By Abraham Levinson, B.S., M.D., Associate in Pediatrics, Northwestern University Medical School; Attending Physician, Children's Department, Cook County Hospital, Chicago; Attending Pediatrician, Sarah Morris Hospital for Children of Michael Reese Hospital, Chicago. Second edition. The C. V. Mosby Company, St. Louis, 1927.

¹ The Tulane University of Louisiana, New Orleans, La., 1926.

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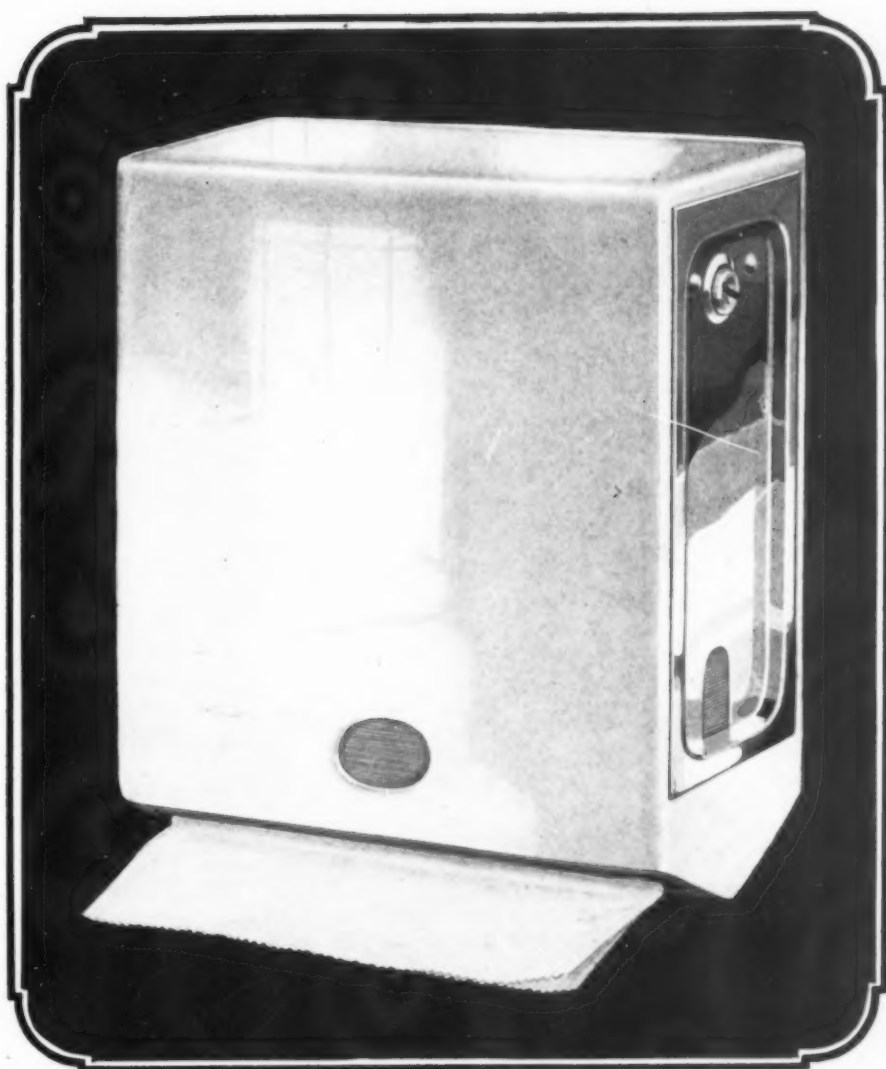
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PUT the lavatories on an economy basis by installing Onliwon Service.

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We have this exact—this scientific knowledge. In equipping hundreds of hospitals of every class, we have stored up a fund of priceless experience.

Daily our experts are called on to analyze food service requirements. Daily our staff submits plans, specifications and estimates—installs and sees through to correct operation complete hospital

systems of food transportation and distribution.

In this we specialize. We have arbitrarily limited our circle of experience to this one factor in hospital management.

This experience—our accumulation of trustworthy data—is yours to use without cost. Feel free to call on us at any time. Let us show you new economies in your food service—short cuts, better service, less confusion, lowered labor costs.

Profit, as hundreds of the largest institutions are doing, by our experience. Write us.

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